

# THE MEDICAL AND SURGICAL REPORTER.

No. 1861.

PHILADELPHIA, OCTOBER 29, 1892.

VOL. LXVII—No. 18

## Original Articles.

### TYPHOID FEVER—ETIOLOGY, PATHOLOGY, DIFFERENTIAL DIAGNOSIS AND TREATMENT.

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Short, concise papers on occasions of this kind are more appropriate and better received than long, statistical ones, but to write briefly and comprehensively where so much is involved would require more skill in writing than I possess. A short, crisp, full and comprehensive definition of a disease, affecting so many parts of the body and attended by such a multiplicity of symptoms as the one under consideration, from its inception to its close, is difficult to produce. Such a definition is desirable because under the head of Differential Diagnosis a continued fever believed by many to be a different, and distinct fever will be considered. In Pepper's "System of Medicine" typhoid fever is thus defined—"An endemic infectious fever, usually lasting between three and four weeks and associated with constant lesions of the solitary and agminate glands of the ileum, and with enlargement of the spleen and mesenteric glands. Its invasion is usually gradual and often insidious. Sometimes the only symptoms present in the beginning are a feeling of lassitude, some gastric derangement and a slight elevation of temperature; at others there are slight rigors or chilly sensations, headache, epistaxis, diarrhoea and pain in the abdomen. The principal symptoms of the fully-formed disease are a febrile movement possessing certain characters,—headache passing into delirium and stupor, diarrhoea associated with ochery-yellow stools, tympanitis, pain

and gurgling in the right iliac-fossa, a red and furred tongue which later often becomes dry, brown and fissured; a frequent pulse; an eruption of rose-colored spots occurring about the seventh or eighth day, slightly elevated above the surface, disappearing under pressure and coming out in successive crops, each spot lasting about three days; prostration not marked in the beginning, but rapidly increasing and occasionally deafness, sweats and intestinal hemorrhages."

When recovery takes place the convalescence is usually tedious and may sometimes be protracted by the occurrence of one or more relapses. Typhoid fever occurs in males and females with equal frequency, in infancy or old age, but is more common under the age of thirty years.

Recent arrivals in an infected locality are more apt to contract the disease than residents.

It is more prevalent during the latter part of summer and early autumn, though it may prevail at any season of the year.

After hot, dry summers and when the water used for drinking purposes gets low it is more apt to prevail. Often heavy rains following a drouth arrest the spread of the fever. Under ordinary circumstances the period of incubation is about two weeks, but in this there are exceptions, fever may begin in three or four days, or not until three or four weeks after exposure. Diarrhoea usually occurs early, the stools being ochery-yellow or dark, following the administration of a purgative or coming on of its own accord. Sometimes constipation persists throughout the disease even in cases that terminate in perforation. Pain in the abdomen usually accompanies diarrhoea.

The abdomen is often tympanitic with gurgling and tenderness in the right iliac fossa. Sir Wm. Jenner says, "Whether there is much distention of the bowel or

not, the convexity of the abdomen is always from side to side, not from above downward, tub-shaped not pot-bellied." The tongue is usually coated, with red edges, pointed, becoming dry, sometimes flaccid or uniformly red and glistening or glazed, or remaining moist throughout. Jenner says, "The small, dry tongue with red tip and edges, smooth furred of a pale brownish color and fissured, the surface seen between the fissures being of a deep red, may be considered differentially as diagnostic of typhoid fever. The tongue is often tremulous and protruded with some difficulty. A papular or pimply eruption consisting of little circular or lenticular spots of a bright-rose color that disappear under pressure, returning as soon as the pressure is removed, appear usually on the seventh or eighth day, but may be deferred until the twentieth day. These spots are sometimes absent in adults and often absent in children. Murchison found them present in 4,606 cases out of 5,988. They usually occur on the abdomen or chest, but they are frequently found on the back, sometimes on the hands and face. These spots frequently do not appear until after the application of a poultice. They come in successive crops each lasting about three days and the number present at one time, according to Watson, varies from one to sixty. No relation has been proved to exist between the copiousness of the eruption and the severity of the disease.

The hair usually falls out after an attack of typhoid fever.

Bronchitis is a common accompaniment. Headache is almost a constant symptom, usually referred to the forehead, often dull and not much complained of, but sometimes excruciating, simulating acute meningitis. Mental hebetude is usually present, but many cases have been reported ending in perforation and death where this condition was absent. Delirium varies with the severity of other symptoms, in the milder form consisting of only slight confusion of ideas easily dispelled by fixing the patient's attention. It may come on in three or four days, often not until the second week, sometimes as late as the fourth week.

In cases of long duration there is sometimes mental disturbance coming on when the fever subsides, amounting to mild insanity. The spleen is sometimes enlarged so that during the second week it may be

detected by percussion but it is often difficult on account of tympanitis, to detect it by palpation. Intestinal hemorrhage may occur during the first week, but oftener from end of second week on. Prostration, approaching collapse, the pulse growing weak and thread-like, the surface bathed in a clammy sweat, the temperature rapidly falling indicate hemorrhage. After these symptoms a discharge of blood will likely occur in a few hours or two or three days. The temperature usually rises again after a hemorrhage has occurred.

Perforation is accompanied by nearly the same symptoms less the rapid fall of temperature and with the addition of sharp and severe pain in the abdomen and the occurrence of general peritonitis in a few days. The absence of liver dullness is considered diagnostic of perforation though it may be present after perforation; case of this kind was reported recently in the *N. Y. Med. Journal*.

Etiology:—Murchison says: "The poison of enteric (typhoid) fever is contained in the emanations from certain forms of putrefying organic matter. Pathogenic (typhoid) fever is often generated spontaneously by fecal fermentation. It is occasionally communicated by the sick to persons in health."

In 1880 Eberth discovered a bacillus which is now generally conceded by pathologists to be constantly present in the spleen and intestinal glands of typhoid cadavers, and that it stands in an etiological relation to this disease. Many experiments have been made with pure cultures of this bacillus, but as none of the lower animals have typhoid fever as it occurs in man, they have not been altogether satisfactory. Dr. Victor C. Vaughn has found that certain toxicogenic germs found in drinking water produce the same lesions in animals as the Eberth bacillus.

Dr. Sternburg in an address on medicine at Yale University, June 28, 1892, sums up the results of experiments with Eberth's bacillus: "It has been shown that this bacillus as obtained from the spleen of typhoid cadavers varies somewhat in different cases, that very similar bacilli may be obtained from water contaminated by sewage, etc., which differ from the typhoid bacillus in certain characters of growth, and yet resemble it so closely, that it is still uncertain whether they are to be considered distinct species or only varieties of

the typhoid bacillus; that the character which was at first supposed to distinguish the typhoid bacillus from all others, viz; its invisible growth upon potato has proved to be unreliable inasmuch as certain other bacteria have been shown to have a like invisible growth, and under certain circumstances the typhoid bacillus may form a visible growth upon potato."

Dr. J. Karlenski has recently published the results of two years' experiments with pure cultures of typhoid bacilli, typhoid dejecta and pieces of organs from typhoid cadavers, buried in earth that was humid, or approached natural conditions.

He ascertained that the longest time the bacilli remained alive in soil was three months. The life of the bacilli in typhoid dejections buried in soil was much shorter than in pure cultures under the same conditions. The deeper the bacilli were buried and the less exposed to sunlight the longer the vitality.

He also found living typhoid bacilli at the end of three months in the organs of persons dead of typhoid fever where the conditions of inhumation were such as to exclude the specific organisms of putrefaction. Typhoid bacilli are widely distributed and do not always produce a specific effect, when introduced into the alimentary canal.

For the past three years I have made numbers of potato cultures from fecal matter passed by patients during the second and third weeks of fever.

At first the bacilli found in undoubted typhoid seemed to differ in size and motion from those derived from doubtful cases. More extended cultures embracing healthy fecal matter, that from privies, and from typhoid fever where hemorrhage from the bowel has occurred, have changed that belief.

It has been claimed that typhoid bacilli and the common colon bacilli act differently upon sterilized milk, one coagulating it, the other not.

I have found no difference both coagulating it in from sixteen to twenty hours, whereas milk sterilized at the same time and in the same way has remained fluid up to the present.

Morphologically bacilli from well defined typhoid cases do not differ from those derived from healthy fecal matter. The intimate relation between drinking water polluted by human excrement and typhoid

fever the acknowledged abundance and distribution of the typhoid bacillus; the necessity for other secondary causes to determine infection, as "individual susceptibility," exposure to agencies that reduce the vital resisting force, virulence and quantity of bacilli, the state of the digestive functions emphasize the probability that the colon bacillus, and Eberth's bacillus are the same.

**Pathology:**—The liver, kidneys, spleen and many other organs or parts of the body, are more or less affected in typhoid fever but its constant and distinguishing lesion is an inflammation of the solitary and agminate glands of the ileum.

These glands are more numerous in the lower part of the ileum and it is here that the poison is usually most active, sometimes extending only a few inches up the gut. The ileo-caecal valve forms the lower boundary of these glands while in the other direction they extend into the lower part of the jejunum. The glands are lymphoid nodules destitute of villi, surrounded by close rows of villi and simple follicles. They are situated on the opposite side of the bowel from the mesenteric attachment. The solitary glands may be affected and Peyer's or the agminate glands remain healthy, but this is not a frequent occurrence. The process begins as a catarrhal inflammation of the mucous-membrane, followed by changes in the lymphatic follicles. Lesions in the lymphatic follicles have been observed forty-seven hours after the beginning of the fever. The enlargement of the solitary and agminate follicles may be slow or rapid, slight or so pronounced as to fill up the cavity of the intestine. Delafield and Prudden in their Pathology, Anatomy and Histology give the following summary of the changes that take place in these glands:

"(1.) If the disease was mild and the enlargement of the follicles moderate, the enlargement gradually disappears and the follicles resume their normal appearance. (2.) In moderate enlargements the retrograde processes affect first the follicles and leave the septa between them still swollen and prominent. This gives to the surface a reticulated appearance. After a time, however, the entire patch becomes flattened and uniform. (3.) The solitary follicles or the separate follicles of a patch



soften, break down and their contents are discharged with some attendant hæmorrhage. This leaves a bluish-gray pigmentation in the situation of each follicle.

(4.) In more severe types of the disease, the enlargement of the follicles ends in ulceration. This takes place in two ways: (a) The enlarged follicles soften, break down and discharge into the intestines. In this way are formed small ulcers. These ulcers increase in size by the same softening process which gradually attacks their edges, and in this way ulcers of large size may be formed. The ulcers may extend outward only to the peritoneal coat, or they may involve the peritoneal coat also and perforate. (b) In the severest forms of the disease considerable portions of the enlarged patches slough, are detached, and leave large ulcers with thick, over-hanging edges. The slough may involve only the follicles or it may involve also the muscular and peritoneal coats. These ulcers also may afterwards increase in size and several of them may be joined together."

#### DIFFERENTIAL DIAGNOSIS.

A differential diagnosis to meet the requirements of this occasion calls for a description of a fever very common in Texas and that has been called "continued fever, slow fever, irritative fever, typhomalarial fever," etc.

During an intimate association of ten years with this fever and carefully noting it in its every detail, I have found the following prominent symptoms: Onset of fever usually insidious, frontal headache, sometimes no pain in head, tongue usually coated, with red edges, becoming pointed and dry as fever advances. Sometimes it is broad or natural in size, either pale or red, remaining moist throughout the disease. Sharp rise of temperature during the afternoon or evening with a fall during the latter part of night and early morning.

Profuse perspirations very common during latter part of night sometimes preceded by chilly sensations and rise of temperature. Epistaxis often occurs during first week, abdomen usually tympanitic and tender in right iliac fossa. Sometimes no tenderness nor tympany exists in this locality but on the left side on a level with and below the umbilicus a circumscribed area of tenderness and tympany exists. In these cases constipation is sometimes pro-

nounced. Bowels often loose especially after first week or following the administration of a purgative. Dejecta often a dirty yellow or brown to red brown or black in color and very fetid.

Often a papular rose-colored eruption more or less abundant on the breast or abdomen often on the back, frequently not seen until after the application of a poultice. These spots have not been observed with the same frequency as we would expect in typhoid fever, but a diligent search will reveal their presence in many cases.

Hæmorrhage from the bowels occurs sometimes. Slight delirium sometimes, only during the night, coming on usually during the second week, from which patient can be easily aroused. Subsultus is often present, occasionally, profound delirium comes on and the other symptoms characterizing the typhoid condition.

New-comers are more apt to contract the fever than those who are acclimated. It is more prevalent during the summer and autumn, especially when the water gets low and noticeably bad in wells. The cause of this fever seems to be impure water.

During the past ten years, in and surrounding the town where I reside, these fevers prevailed almost exclusively, where well-water had been used for drinking purposes. A few cases have occurred where cistern water was used, but the faulty manner of collecting and preserving it gives ample explanation. During 1884 a well sunk the previous year upon the business street of the town, was much patronized on account of the purgative and other supposed medicinal properties of the water. Many who used this water had the fever. A chemical examination revealed the presence of albuminoid ammonia.

During the early days of McGregor and up to a year ago many of her citizens used well-water, others brought water from portable tanks that were supplied with water from springs far removed from fecal contamination. These wells are sunk in porous shelly and fissured rock to a depth of from fifteen to thirty feet where a compact blue limestone is encountered. This blue limestone is the lower limit of the surface, water bearing, rock and is so compact that water does not penetrate it.

Of those who used well-water many contracted fever with the symptoms above



given, while of those who brought water from the tanks not a single case came under my observation.

One year ago water works were put in, the supply being from artesian wells 1,000 feet deep and cased so as to exclude all surface water. Up to the present not a single case of fever has been developed that could be traced to this water. On the other hand there are some families who from choice, or on account of living in outside districts of the town still use surface well-water. Among these the fever has been very common.

In August, 1891, a fire occurred in a stone building that contained 100 tons of baled hay. Fifty gallons of water per minute was thrown into this building for a period of twenty-four hours, and not a drop ran off on the surface.

Two days afterward a couple of wells 700 yards east, one 200 yards south and two west, 300 and 400 yards respectively, were found so strongly impregnated with the taste of burnt hay that the water for several weeks was totally unfit for use.

The description of the surface wells in McGregor is a description of the surface wells throughout this country where numbers of cases of fever have occurred.

I would give some illustrative cases, but this paper is already too long. Before proceeding further I wish to state distinctly that I have seen fevers continue from three to fourteen days due to malaria, or errors of diet, etc., but these lack the distinctive abdominal lesions above given. The fevers I have observed never terminate under eighteen to twenty-one days, and often longer. Now for the differentiation: Typhoid fever is nearly always derived from impure water, especially that contaminated by human dejecta. The same is true of "continued fever." Typhoid fever is marked in the majority of cases by certain abdominal peculiarities—, tympanitis and tenderness in right iliac fossa, "tub-shaped," loose bowels occurring after the administration of a purge or coming on of its own accord, sometimes constipation throughout the disease. "Continued fever;" acts the same way. In typhoid fever hæmorrhages from the bowels sometimes occur. The same may be said of "continued fever."

A papular eruption occurs in typhoid fever in a certain proportion of cases. It is sometimes present in "continued fever."

Other causes than the presence of the typhoid bacillus are necessary to determine infection, therefore every one who is exposed does not contract the disease.

"Slow fever" requires the same secondary causes, therefore only one or two cases may occur in a family.

Typhoid fever sometimes drifts into the typhoid condition, which is thus graphically described by Tweedie: "It is announced by the decline of the previous more acute symptoms, by the pulse becoming more rapid and soft; the tongue dry, brown and tremulous and protruded with difficulty; by the incrustation of the teeth with sordes; by the increasing intellectual disorder indicated by the constant low muttering delirium and the greater insensibility and deafness; and by the condition of the muscular system which is evinced by muscular tremor and subsultus tendinum and in some cases by irregularity or intermission of the pulse; by the patient lying sunk on his back, or sliding to the foot of the bed, the muscles being unable to support the body even in the horizontal posture." "Continued fever" may drift into the typhoid condition with all of its attendant symptoms.

I think it is unnecessary to pursue this comparison any further, "things equal to the same thing are equal to each other," therefore, "continued fever" as it occurs in Texas is typhoid fever. It is there that in a great many instances it is very mild, much more so than we have been taught to expect in typhoid fever, but is not the abundance of pure air and the lack of concentration or virulence of the poison sufficient to account for it!

Until the pathology of "continued fever" is shown to be different from that of typhoid fever, or in fact until its advocates advance some pathology for it, I think it would be well to call it typhoid fever, or better, enteric fever, which would be a better name for both.

#### TREATMENT

The treatment of typhoid fever requires more watchfulness and diligence on the part of the physician and a stricter compliance with instructions on the part of the patient and nurse, than almost any other disease.

Nothing is more important than a definite understanding with both patient and attendants early in this disease.

To get the best results the physician's instructions should be faithfully carried out.

When a diagnosis of typhoid fever is made the patient should be put to bed and required to remain there until he is clear of fever during the whole day.

Strict cleanliness and thorough ventilation of the sick chamber should be insisted upon. This will necessitate frequent changes and airing of bed linen.

The next and one of the most important things to be done is to regulate the diet, or rather prescribe a diet. Only liquid food should be allowed under any circumstances. Sweet milk mixed with lime water to prevent coagulation, chicken water, beef essence, beef tea or a soft boiled egg, are often well tolerated, and serve the purpose admirably well, but I think nothing is so good and generally acceptable to fever patients as fresh cold buttermilk. It is impossible to prescribe the exact amount of milk that should be given; this must be determined in each individual case. Some patients will take from four to six glasses of milk during twenty-four hours while others are unable to take more than one or two without discomfort.

The alvine discharges indicate very clearly if too much is taken by containing undigested lumps.

In the application of medicine we should ever bear in mind that we are dealing with a self limited fever; one that under the most favorable conditions will continue from eighteen to twenty-one days.

We should also remember that it is not out of the natural order for the temperature to rise during the afternoon and evening and that unless it reaches  $103^{\circ}$ , no active measures should be resorted to, to lower it.

Another point worthy to be remembered is that antipyretics administered during the afternoon and early evening may not have the same effect as when given during the latter part of the evening or early morning. Doses sufficient to make only a slight impression upon the fever when it is rising being sufficient, to often, produce perspiration and prostration if given near the time when the fever naturally, starts down.

After feeding, the regulation of temperature is next in importance. Antipyrine, Acetonalid, Phenacetin, Antikamnia and other similar preparations often do good

service in this direction, but they should be carefully watched lest the depression produced counterbalance the good. In many cases cold water is all that is needed to regulate the temperature. Sponging the body with cold water, using the wet pack, putting patient in a cold bath or a graduated bath, are perfectly safe. For a bath nothing answers the purpose better than an ordinary cot, with a piece of rubber cloth spread over it. The patient wrapped in sheet, placed on this cot and water poured on until the temperature is sufficiently reduced.

After reducing the temperature with water, quinine in daily doses ranging from twenty to forty grains is often sufficient to keep the temperature within the normal bounds.

Quinine cannot be given indiscriminately in this fever. Some cases will not tolerate it, and if its use is persisted in will produce most disastrous effects. I have found where patients tolerate quinine it is best given during the morning hours, the daily amount being given in three or four doses.

Turpentine stupes over the abdomen when there is pain and tympanitis, are very comfortable to the patient and useful. Mineral acids, though very much used a few years ago, are rarely prescribed now, as they are found to do very little good except as a solvent for quinine.

Some recent discoveries, however, in regard to the gastric juice in febrile conditions, will justify the use of one of them. Gluzinski has found in a patient whose temperature was not above  $102^{\circ}$ , total absence of hydrochloric acid and not until the temperature reached the normal was there a trace of this constituent of the gastric juice.

There is always a diminution and often total suppression of hydrochloric acid in the gastric juice in febrile conditions. It is further asserted that the dyspeptic condition in fevers is due to the absence of this acid. This suggests the propriety of administering it combined with milk, as has been done in summer complaint.

Whenever the patient begins to show weakness whiskey or brandy should be given judiciously every 3 or 4 hours.

I think the advice given by many authors to wait until the two sounds of the heart can't be distinguished from each other before exhibiting stimulants, is erroneous.

This condition of weakness may be avoided by the timely administration of whiskey.

It is important to regulate the bowels; if they do not act give a mild purge; if this acts too freely use tr. opii, or tr. opii and bismuth. Often twenty or thirty drops of tr. opii given per rectum will control the bowel much better than if given per mouth.

Sleep is a very important factor in the treatment of typhoid fever. It has been said if a typhoid fever patient spends three successive nights without sleep, recovery is extremely doubtful. Chloral and pot. bromide are sometimes beneficial in the way of securing sleep, but I have found them rather weakening and unsatisfactory in many cases.

Tr. opium or sulph. morphia I think far preferable.

The specific treatment of typhoid fever has never given general satisfaction. Dr. Gustavus Eliot, of New Haven, Conn., in a recent article published in the *New York Medical Journal*, extols the German calomel treatment followed by tr. iodine and carbolic acid, as suggested by Bartholow. My experience with calomel has been very unsatisfactory. I have observed that in patients who take very much calomel during the early stage of fever, precisely the time it is recommended to be taken, hæmorrhages from the bowel are more apt to occur.

I have just dismissed two patients who took of their own accord, large doses of calomel. One had rather an alarming hæmorrhage from the bowel followed by prostration and a tedious recovery; the other had an alarming hæmorrhage followed by death two days afterward.

Tincture iodine and carbolic acid, listerine, zymocide and other drugs of the same class may be useful in correcting the fetor of the discharges, and thereby lessening the intensity of the inflammation.

The internal administration of turpentine when the tongue is tender, is often followed by the most gratifying effects.

When the symptoms indicating hæmorrhage occur, ergotine hypodermically, and tr. opium administered by mouth, pushed to the limits of safety, are most useful. The propriety of applying cold to the abdomen, on account of the prostration and lowered temperature is extremely doubtful.

Perforation should not deter the physician from further efforts to save his patient because cases of recovery have been recorded by persons whose skill as diagnosticians can not be questioned. Here opium is the sheet anchor, because if sufficiently pushed it will keep the diseased bowel as effectually immobile as if it were placed in a splint.

Laparotomy has its advocates and no doubt lives may be saved by it, especially since suturing the bowel has reached such a degree of perfection that sections of it may be taken out.

This paper is not intended to be a full exposition of the symptoms, pathological changes, differential diagnosis, and treatment of this fever, but an effort has been made to present as briefly as is consistent with clearness, the more salient features of each.

A chapter on propylaxis might be written, but as it does not come within the scope of this paper and as it is already too long, a repetition and partial endorsement of the language of some one, I cannot now recall whom, will end this paper:

"Typhoid fever should be considered a disgrace to our modern civilization."

#### PARAPLEGIA OF SYPHILITIC ORIGIN.

Dr. Boulloch gives statistics to show that in sixty-two per cent. of cases the paraplegia shows itself during the first four years following the chancre. In eight instances it occurred in the first year. Retarded myelitis, that is coming on long after the chancre, either in the midst of tertiary accidents, or after a long period of inactivity, is of very rare occurrence. Figures show that medullary affections seem to burst forth twice as frequently in those who have had no mercurial treatment or only an insufficient treatment, as in patients who have been well cared for. Chronic myelitis is rarely fatal, but is also rarely cured. It appears as though paraplegias accompanied by severe pains are benefited more by mercury than the other, perhaps because of the existence of a gummosis or sclero-gummosis meningitis. Acute paraplegias, of precocious nature and rapid march, do not get well. Improvement is frequent in the tardy forms.—*Journal de Médecine.*



## Communications.

### WOUNDS OF THE BRAIN AND THEIR RESULTS.

By FRANK P. NORBURY, M. D.,  
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Wounds of the brain are worthy of our greatest consideration.—The diagnosis of the extent and location is difficult when the wound is without the motor areas. Extra-cranial symptoms do not indicate the extent of brain injury. It is often impossible to differentiate the form of brain wound.

Clinically wounds of the brain may be classed as follows: *contused, lacerated, penetrating and complicated.*

*Contused* wounds may be followed by shock only, and the symptoms of concussion are then pronounced. The severity of a contused wound is measured by results, if destruction of brain substance (red softening) follows, nutritive interference has ensued. Such changes are usually confined to cortex, but interior areas and nuclei of brain may be bruised by severe forces.

Secondary consequences of contused wounds are manifested in insanity and other neuroses. Insanity may immediately follow concussion or, at a period remote, mental changes, progressive and chronic, essentially degenerative, may develop. Clinical study of 2,600 cases seen by me shows traumatism so be a factor in the causation of insanity of greater import than that usually ascribed to it. The forms of traumatic insanity are illustrated in the three following cases, viz: Case I. S. S., age 64, farmer; insane two months; cause concussion of the brain; mental derangement immediately followed brain injury; hallucinations of sight for a time; delusions of persecution; carried money on his person to prevent its confiscation. No motor disturbance; slight anæsthesia right side, impaired hearing. Improved rapidly under treatment, made good recovery. Case II. G. E., age 18; laborer; insane one year. Cause a blow on the head. Incoherence followed the regaining of consciousness after the injury. Neurasthenia rapidly developed. He was treated for typhoid fever; the mental symptoms

—hallucinations and delusions of persecution—were present from the beginning of the neurasthenia. When admitted was more or less somnolent, stupid, incoherent and very feeble. Four months elapsed before evidence of mental improvement was noticed. Gradually improved and recovered after seven months' stay in the hospital. Case III. J. W. Z., age 36; carpenter: Insane three weeks on admission. Cause unknown. Four years before had fallen from a scaffold striking on his head, causing depressed fracture left parietal bone. Nothing was done surgically: One year after injury a change in disposition was noticed and gradually he was turned against home and friends. He left home and soon after other changes were noticed. Intense headaches, insomnia, etc., developed and finally delusions of persecution and some hallucination. He gradually lost his hearing. When admitted showed unmistakable evidence of organic disease of the brain. Motor symptoms marked also sensory changes. The disease was so far advanced as to make prognosis as regards life very unfavorable: he died within a year of organic disease of the brain—*pseudo-paresis*.

Lacerated wounds are associated with contused wounds and always when concussion exists. Hemorrhages are frequent in lacerated wounds, the clots cause paralysis; hemiplegia when whole motor area is involved—monoplegia when one single locality, as in motor aphasia when Broca's convolution is affected. Idiocy is the prominent result of lacerated wounds of the brain, fully one third of all idiocy is due to traumatism. The meningeal hemorrhage resulting during parturition from protracted pressure or instrumental interference, is responsible for nutritive interferences to the brain, atrophy results and may be accompanied by convulsions, spastic contractions, athetosis, etc. An examination of the brains of idiots or imbeciles whose mental derangement is due to traumatic brain lesions, shows in most all cases conclusive evidences that atrophy, sclerosis, etc., were due to nutritive changes, induced by the brain injury.

Porencephalus is undoubtedly due to traumatism occurring during parturition or to injuries occurring later during infancy. Wounds of the brain during infancy are of more serious import than is usually supposed; a statistical study of the results

would be a sad revelation to careless parents. Inflammatory changes are common in infancy and the result is atrophy and sclerosis with attending mental, motor and sensory changes.

Penetrating wounds of the brain are of serious nature; the degree depending on the location and on the substance penetrating. Antiseptic treatment of such wounds has done much to save life. Gunshot wounds of brain are most fatal, because of great destruction to brain substance.

Complicated wounds of brain are the most common. They include all the foreign classes and in addition have fracture of the skull associated, hence the term complicated. Indications of treatment are to relieve hemorrhage, pressure symptoms, and make wound aseptic. Base may be fractured; if so have sense interval, and on this base diagnosis.

Results of complicated wounds may be all those given in other classes and in addition suppuration, meningitis, brain abscess, epilepsy, aphasia, paralysis and general disturbances of sensation; antiseptic precautions lessen liability to suppurative meningitis. Brain abscess never occurs unless there is solution of the continuity of the surface. Every traumatic abscess is preceded by a wound which communicates with the surface in some way.

Traumatic epilepsy has some focal point of irritation due to pressure or nutritive interference with cortical areas. It may be relieved by relief of pressure, either by elevation of depressed bone or by removal of clots of blood on the surface of the brain. Relief must be given early if good is to come from it. Delayed operation is never productive of permanent relief. Early operation is advised. In children we must operate on first appearance of convulsions, ere sclerosis is too far advanced.

#### EPILEPSY.

In a severe case, after failure of other remedies, Dr. J. A. Proctor, of Union City, Ind., resorted to the following combination (*Med. Bull.*) Under its influence attacks ceased and have not recurred more for than two years:

<b>R</b>	Sodii boratis.....	
	Ex. spigellæ fl.....	
	Tinct. calumbæ.....	
	Ex. stargrass fl.....	
	Tinct. sanguinariae.....	3 ij.
	Ex. pulsatillæ fl.....	3 j.
	Aqua, q. s. ad.....	℥j.

M. Sig.—Teaspoonful three times a day.

## Society Reports.

### OBSTETRICAL SOCIETY OF PHILADELPHIA.

Meeting of October 6th, 1892.

THE PRESIDENT, Dr. W. H. H. Githens, in the chair.

DR. WILLIAM J. TAYLOR related a case of "Twin Pregnancy Complicated by a large Myoma in the Right Broad Ligament—Abdominal Section and Removal of Three Tumors—Abortion—Recovery."

Two years ago he had exhibited to this society three tumors which he had removed by abdominal section—a large myoma from the broad ligament, and two smaller subperitoneal ones from the posterior and upper surface of the uterus. The case had, at that time, elicited much adverse criticism and he thought the subsequent history of the patient might prove of interest. The patient had always been healthy; had worked on a farm in Ireland, often doing the work of a man. When first seen by Dr. Taylor, there had been absence of menstruation for five months. There was constant nausea and vomiting, the tongue was dry and somewhat coated. The pulse was rapid, 120 per minute, and very weak. There was diarrhoea which had lasted for several days. The urine contained albumen. She complained of great pain in the abdomen, especially on the right side. The bladder was very irritable. There had been no bleeding or discharge from the uterus. The breasts showed well marked signs of pregnancy and contained milk. The abdomen was enlarged and in the right iliac region was a mass about the size of a small cocoanut, which was hard, fixed and painful. This tumor had been growing very rapidly and was becoming more painful every day.

The diagnosis was obscure and Dr. Taylor was in doubt whether it was an extra-uterine pregnancy or a rapid growing myoma. At the section, two large tumors presented which were joined below but were separate above. The tumor to the left was the pregnant uterus while to the right was the new growth. The great mass of the tumor was between the layers of the broad ligament—a true intra-ligamentous myoma. This was enucleated from its

capsule and removed. There were two sub-peritoneal myomata, about an inch and half in diameter, which were also removed, one from the upper and one from the posterior surface of the uterus. Several small myomata, dotted here and there over the surface of the uterus, were allowed to remain. The patient reacted well from the operation, which was one of great difficulty and consumed much time, especially in the arrest of hemorrhage.

She did well until the sixth day when she began to show signs of aborting and suffered great pain in the region of the wound especially. For this reason and in the fear that persistent and active uterine contraction might do serious damage, and as the os uteri was widely dilated and a foot of a fetus presented, active interference was decided upon. A fetus of a little over four months' development, along with its membranes and placenta, was removed and it was thought that the uterus had been emptied—the manipulation being of necessity very limited for fear of doing damage to the wound. On the eighth day, she was delivered spontaneously of a second fetus, which was alive and lived for an hour. Up to this, her attendants had no suspicion of a twin pregnancy. Except for an attack of phlegmasia dolens, her recovery was satisfactory. Some time after leaving the hospital she suffered from persistent diarrhoea which exhausted her greatly and refused to yield to treatment, finally ceasing spontaneously.

Fourteen months after the operation she was delivered of a fine boy, now alive. Dr. Taylor did not attend her in the labor but learned from her that she was in labor about sixteen hours and that she had intense pain. The perineum was badly lacerated. Again she became pregnant and was delivered of a healthy girl. She now comes to Dr. Taylor suffering with a torn cervix and badly torn perineum with an almost complete prolapse of the uterus. The abdominal scar is in perfect condition and there is no evidence of trouble at that point.

#### DISCUSSION.

DR. B. C. HIRST said that he considered the case remarkable for two reasons. The hemorrhage was extremely alarming from its profuseness and from its situation. In the second place he thought the abor-

tion due to the death of the fetus and not to the operation. If it had been due to the operation, it would have occurred sooner. He was glad to see the course that was pursued and that the procedure was justified by the subsequent history of the case.

DR. M. PRICE made a few remarks on the subject of "Emergency Cases in Abdominal Surgery" and presented the following cases:

#### 1. RETENTION OF URINE.

The patient was seventy-nine years old and suffering from retention of urine due to an enlarged prostate. He had been unable to pass urine freely for a long time and for several months it had been constantly dribbling. It was impossible to pass a catheter. The Hunter Maguire operation of supra-pubic cystotomy was performed, the bladder freely washed out and stitched to the abdominal wall, a rubber drain having been introduced with a gauze drain above and below it. Patient passed urine freely through the rubber drain; all drainage discontinued after the sixth day. Hunter Maguire's aluminium plug was used to keep the opening into the bladder patent. The prostate was as large as a double fist. Patient recovered.

#### 2. TUMOR OF RIGHT TUBE.

Patient twenty-eight years old, suffering from a small tumor of the right tube, the left being densely adherent and cirrhotic, not larger than a lima bean. She had been an invalid for six years; one year and a half under the rest treatment; electricity by a celebrated gynecologist. Patient made an excellent recovery.

#### 3. REMOVAL OF OLD PUS-TUBE.

The patient, a colored woman, twenty-six years old, had contracted gonorrhoea from her husband at the time of marriage, but had recovered so far as vaginal discharge is concerned. She had been unable to work for a long time, owing to frequent attacks of pelvic trouble, and was a confirmed invalid. The tumor extended above the umbilicus, rather to the left of the median line, and contained pus, blood and a watery fluid. There had unquestionably been a rupture of an old pus-tube and a violent general peritonitis. Two-thirds of the pus sac was enucleated and



tied off. It was impossible to remove the other third as the adhesions were stronger than the sac itself, and it was adherent directly over the iliac vessels. Thorough irrigation and gauze and glass drainage; recovery.

#### 4. ECTOPIC PREGNANCY.

Patient thirty-six years old, suffering from terrific hemorrhage from a ruptured ectopic pregnancy. She was pulseless at the time Dr. Price saw her, ghastly pale, respiration sighing, sick stomach, with a feeling of something in the bowel, constant diarrhoea, distended abdomen, normal temperature. As soon as the abdomen was opened, blood poured from the incision. The ruptured tube was delivered and tied off. At least a pint of clot was removed from the pelvis; quantities of liquid blood also discharged. Thorough irrigation and glass drainage for six days; free purging and liquid diet after the second day. The patient rallied from her hemorrhage very slowly but made a perfect recovery.

#### 5. RUPTURED DERMOID OF THE RIGHT SIDE.

Patient had been suffering from the tumor for five years and had had repeated attacks of peritonitis. During the very hot weather the tumor ruptured and from that time on she suffered from peritonitis; the bowels at the time of operation, September 3rd, being covered with inflammatory lymph and looking very much as if parboiled. A number of pitchers of water were used for irrigation and a glass drainage tube inserted. She made an uninterrupted recovery.

The water used in these cases was plain boiled water, cooled down by other not boiled and seemed to get rid of microbes so far as could be judged by the effect on the patients and their recovery.

#### 6. PYOSALPINX AND OVARIAN ABSCESS.

A pyosalpinx and ovarian abscess of the right side, resulting from gonorrhœal infection at the time of marriage, had been removed from this patient. At the time of operation the left side appeared healthy, but the principal reason for leaving it was the already almost hopeless condition of the patient. Drainage was continued for four days and was followed by a fistulous track through which the patient menstruated regularly and which

persisted for seven months in spite of efforts to close it. At the end of seven months it ceased discharging and her physician found her to be pregnant. Owing to indiscretions in lifting, she miscarried but recovered nicely from this and in the latter part of 1891 again became pregnant and was delivered of a healthy girl.

Dr. Price stated that this was the third case of undoubted gonorrhœal tubal troubles where one side was left. One had to be operated on the second time. This one now reported and the third remained perfectly well.

#### 7. TUMOR OF ABDOMEN COMPLICATING PREGNANCY.

The patient was thirty-one years old; always healthy. Four months after marriage she became pregnant but her abdomen enlarged much more quickly than a pregnancy of one or two months would account for. She was suffering from severe peritoneal pain and constantly increasing distension, with a large tumor on the right side extending up to the kidney. Her condition demanded immediate relief and a large fibroid was removed along with the pregnant uterus containing a dead fetus of about three months.

The specimen was of great interest and from the large growth, sarcoma rather than a pure fibroid was suspected. The walls of the uterus were thickened in all directions and from their unyielding character had caused the death of the fetus at this early date. Patient recovered without any complication.

#### 8. TWO CASES OF APPENDICITIS—OPERATION.

The first patient was suffering with a well marked tumor in the right iliac fossa of ten days' formation. First attack of appendicitis. Persistent constipation for five days. Six to eight ounces of pus were discharged. Thorough irrigation; gauze packing. Recovery without any trouble.

The second patient had been suffering from mild attacks for fifteen years; never so severe as to completely incapacitate him for work. The last attack began with severe and agonizing pain in the region of the appendix. Hypodermic injections of morphia with free purgation were used for

a few days with seeming relief. His symptoms increased in severity and Dr. Price was called in consultation. At the operation, the intestines were found matted together and were separated with great difficulty. Six to eight ounces of black, offensive pus were evacuated; thorough irrigation of the peritoneum and abscess cavity, with gauze packing and a rubber drainage tube of large calibre in the abscess cavity and a gauze drain also of the peritoneal cavity. Complete recovery.

#### 9. STRANGULATED DIRECT INGUINAL HERNIA.

The patient had been vomiting questionable matter for four days. The bowel was dark but not gangrenous, so it was freed and examined for bands of adhesions and washed with boiled water that had been cooled down to a proper temperature. Recovery was rapid.

Dr. Price also presented a paper on Hard Tumors of the Uterus. He said that many of these tumors are of varied and entirely different pathological appearance and would seem to have originated from different causes or conditions in fibroid changes. These tumors are of low vitality and prone to develop rapidly into malignant forms of disease.

Dr. Price stated that he had examined over one hundred of these hard tumors to ascertain the manner of their growth and development. In the true fibroma there is but a trace of muscular fibre and but little connective tissue and most of that in its capsule. The vascular supply is almost entirely in the capsule, with small vessels running into the tumor. As the tumor advances in size the vascularity of the capsule increases.

In the myomatous tumors the bloodvessels are very numerous throughout the tumor, tortuous, and of large caliber. The muscular element can be demonstrated without difficulty and the growth of the tumor is much more rapid, in comparison with the hard nodular variety, and is much more apt to be confounded with pregnancy. The myomatous variety is much more apt to be diffused, or one face of the uterus covered with the growth, with the uterine canal passing half round the tumor. Dr. Price had never seen a tumor that occupied the entire walls of the uterus. The nodular variety has its beginning, in most instances, in the mus-

cular structure of the uterus and may travel in its growth either to the uterine cavity or in the direction of the peritoneal cavity: the latter being the most common, as that is the direction of least resistance. In either case they may become pedunculated. It is rare to see a true hard fibroid single: most of them are multiple, with one large nodule surrounded by a number of smaller ones.

#### DISCUSSION.

DR. WILLIAM J. TAYLOR asked if it would not have been possible to have removed a portion of the prostate, in the case of enlarged prostate, so as to give a passage through the urethra.

DR. PRICE replied that he could have removed the prostate, but that it was situated very deeply and he thought the patient could do better as he is.

DR. B. C. HIRST reported the following case of "A large Collection of Pus Between the Layers of the Broad Ligament Complicating Pregnancy." The patient was a middle aged woman in the fifth month of pregnancy, a number of years having elapsed since the last child. She had been confined to bed for about eleven weeks. A large tumor could be made out alongside the uterus and at the section a cystic tumor was found between the layers of the right broad ligament, containing about two quarts of pus, which was incised and the pus evacuated. The sac was sewed to the abdominal wall. The woman recovered. Dr. Hirst thought that it was likely that this was a suppurating intraligamentary cyst. He thought it remarkable as complicating pregnancy, and as an unusual termination of a monilocular broad ligament cyst, which usually contains a clear limpid fluid; not at all prone to septic changes.

#### DISCUSSION.

DR. CHARLES P. NOBLE said that this question of abscess under the peritoneum is an interesting one, but he thought that, unless Dr. Hirst is more definite in regard to the real nature of this abscess, it has not very much bearing on the question whether you have broad ligament abscesses or not. He thought the case did not come under the head of broad ligament abscess, but of suppurating broad ligament tumor. He had seen a number of broad

ligament abscesses but they had all been puerperal.

DR. M. PRICE said, we have never denied that there may be abscess anywhere, in the broad ligament or between the folds of the peritoneum in any portion of the abdomen, but what we do deny is the frequency of these things and the ability of the operator, with his finger in the vagina, to say whether the mass is inside or outside the peritoneum. These collections can be drained outside of the peritoneum but what have you done? You have attempted to drain an abscess, with probably a necrotic tube, diseased appendix or some other condition inside, which will keep up the trouble for a long time, probably with a fistulous tract for months. The only proper treatment is to go into the peritoneal cavity and remove the diseased condition that has produced this abscess; let it be exterior or interior to the peritoneum. Eighty or ninety per cent. of all pelvic troubles have been in the start intraperitoneal and have been taken care of by nature and at the time of operation are found extra-peritoneal, having been shut off from the general peritoneal cavity by inflammatory adhesions. There are cases of puerperal trouble where, from laceration of the cervix, an abscess has formed in the cellular structures around the cervix, but these abscesses are exceedingly rare, so rare that a man scarcely sees one of them, while the other condition is common.

DR. JOSEPH PRICE said that this paper opens up some points of dispute in regard to pathology, natural history and surgery and he should like to make a few remarks in regard to his own personal experience. He was not willing to accept the literature on this subject of intra-ligamentary cyst. The reported cases are all on record in doubt, as the one this evening. The reporter is still in doubt as to the character of the tumor—he thinks it contained pus. We know that parovarian cysts contain a clear fluid which is the least likely to change. It is the purest form of liquid which we remove from the pelvis. He had never known a parovarian cyst to suppurate. It was his impression that in the case reported, the enucleation would have been easy. He was not willing to say that the patient was well. The time will probably come when it will be necessary to repeat the procedure and remove the tumor. He

had yet the first case of intra-ligamentary or broad ligament cyst to see.

He had removed many ovarian abscesses and pus accumulations and after removing them, he could hold up the remains of the broad ligament to the light and demonstrate clearly that there is not the semblance of suppuration in the cellular tissue at that point. He knew that abscesses occur at all points where we find cellular tissue, but, in the vast majority of cases, pelvic abscesses are due to traumatism or to extension. They occur in the cellular tissue precisely as in the ovary. Ovarian abscesses in 99 out of 100 cases follow a suppurating tube. There is an attachment of the pavilion-end of the tube to the ovary through which infection takes place and abscess develops. It is folly to take the position that these things are primary and that they do occur in the broad ligament so frequently without cause.

DR. BARTON C. HIRST in closing the discussion, remarked that the usual contents of broad ligament cysts being so pure, he had been surprised to find an abscess in that situation.

DR. J. M. BALDY reported a case of chronic abscess due to appendicitis. The patient had been sent to him for an opinion in regard to a rapidly growing tumor that had first been noticed two years previously as a small protrusion from the external inguinal ring on the right side. A truss had been applied under the impression that it was a hernia. When seen by Dr. Baldy the growth was the size of a fetal head and had much the appearance of a sarcoma. At the section, a quart or more of pus escaped and the abscess cavity was found situated between the skin and muscles, with an opening at its lower end which communicated with the head of the cæcum, dipping down behind the muscles at their attachment to the iliac bone. The cavity was carefully irrigated and two drainage tubes were placed—one extending behind the muscles into the abdominal cavity, the other in that portion of the cyst between the muscles and the skin. Recovery was slow but good. On careful inquiry after recovery, the following history was elicited. She had had some three or four years previously an attack of inflammation in the region of the tumor, which lasted for several weeks and gradually left her. She had thought nothing



more of it and had not connected the so-called hernia with it. The original attack was undoubtedly an appendicitis and the pus cavity had existed in a quiescent state for years.

Dr. Baldy also reported a case of malignant peritoneal cyst and stated that he had called the tumor by this name as he did not know how else to call it, never before having seen or heard of such a condition. Before operation he had considered the tumor a par-ovarian cyst, free from adhesions. The uterus and ovaries could be palpated and were free from disease. At the operation the cyst was found densely adherent to the abdominal walls and the point of division was found with difficulty—the sensation imparted being that of passing through connective tissue. In attempting to break through the adhesions at the upper margin of the tumor, the finger slipped and entered the cyst itself, emptying it of a gallon or more of dark, flaky fluid. The interior of the cyst cavity was lined with a soft, velvety, membrane, studded all over with either tubercular or malignant nodules. The posterior wall seemed made up of coils of intestine, covered with this velvety membrane. The ovaries had both undergone cystic degeneration. To the side of both ovaries, and apparently growing from them, were papillomatous masses. The tubes were shortened and thickened, the fimbriated ends both perfect, but short and stumpy; and the uterus quite large and heavy. The whole pelvic cavity formed part of the cyst cavity, the bladder bulging into it in front.

A drainage tube was placed in each flank, between the cyst wall and the abdominal wall; and a third one inside the cyst, to the bottom of the pelvis. The patient's recovery was slow but satisfactory. She still has a sinus into the pelvis, which discharges a variable amount of thin fluid from time to time.

Dr. Baldy stated that the only explanation he had been able to make of the case was, that there was a congenital anomalous distribution of the peritoneum, which, later in life, took on malignant changes.

#### DISCUSSION.

DR. JOSEPH PRICE said that this was not the proper society to discuss the subject of appendicitis, as the men are not here who cure these by palliative measures, opium and rest. These men tell us of the

cases that they have treated in this way, following the opium by a little calomel or a little rochelle salts and the patients have done fairly well. On inquiry we learn that other cases, treated by them in the same way, have not done so well, and that after continuing the treatment for several days, they have finally called in a surgeon when the patient was in a dying condition. These patients often carry these abscesses for several years, travelling from one part of the country to another in search of relief, having as many as twenty-four attacks, and the case goes on record by twelve physicians, each curing two attacks. He has presented specimens here, removed in the fourth, fifth or sixth attack, that some one else was reporting as a recovery under palliative treatment. Not a week passed this summer without a case of appendicitis. All of them had been neglected, all had had a number of attacks treated by so-called medicinal or palliative treatment without the slightest relief.

DR. GEORGE E. SHOEMAKER said that, while it is difficult to criticise a case that one has not seen, it seems reasonable to suppose that the so-called peritoneal cyst reported by Dr. Baldy, was a case of tuberculosis of the peritoneum which had caused adhesion of the bowels to each other and a large accumulation of fluid between the parietal and visceral peritoneum and that the parietal peritoneum was largely thickened and that this had been stripped from the abdominal wall, as Dr. Baldy himself thought. The peritoneum in these cases does become greatly thickened. Some of his own cases suggested this view.

DR. HARRIS A. SLOCUM suggested that a possible explanation of Dr. Baldy's case of peritoneal cyst is congenital enlargement of the urachus. He could understand how such a condition might occur—first enlargement, and then malignant change. Under such circumstances there would be found marked adhesion in the middle line.

DR. JOSEPH PRICE said that tubercular peritonitis often simulates cystoma. It was his impression that this was a case of tubercular peritonitis.

DR. J. M. BALDY said that it had always been his custom to open chronic abscesses. In the vast majority of cases the appendix is already destroyed. He

could have gained nothing by opening the general peritoneal cavity.

In regard to the second case he was rather inclined to regard it as malignant and not tubercular. The ovary was undoubtedly malignant, and it seems right to assume that the rest of the disease was also of a malignant nature.

DR. JOSEPH PRICE presented specimens of extra-uterine pregnancy. These specimens are of interest, he said, and there were a few points about them that he would like to discuss. In the first place as to position; he thought they are primarily all tubal. In looking over the literature of the subject, he finds that there is a disposition among prominent operators to drop down from the position they once held in regard to intra-ligamentary or broad ligament rupture. As yet Dr. Price had the first *broad ligament* hæmatocele or extra-uterine pregnancy to meet, and this with an experience of eighty-two cases. Rupture takes place at all points of the tube except at the crest of the ligament, which he believed to be the strongest portion. The pavilion extremity is the most common seat of rupture.

In these cases death is a matter of hæmorrhage and shock. The escape of a pint of blood into the peritoneum will sometimes kill, while a hæmorrhage of a quart from the vagina or uterus will not kill. The peritoneal cavity will not tolerate this blood. It is something aside from the mere loss of blood that kills. The danger from hæmorrhage is the chief danger. Until this summer, suppuration had not occurred so often in his experience. The last three cases, in which there was pre-existing tubal and ovarian disease, had suppurated. He was satisfied that there was an advanced form of tubal disease, which favors tubal pregnancy and also favors suppuration of the placenta and fetus after rupture. The quiescent cases that suppurate and come through the bladder and bowel are unfortunate cases. In many there is a fecal fistula.

The child free in the abdomen is quite a common occurrence. In Jessop's case there was a live child free in the abdomen. Three or four such cases have been reported. Dr. Price thought there was a case of Dr. Atlee's in which a child weighing nine pounds was found among the intestines.

ELLISTON J. MORRIS,

*Sect'y.*

## THE SURGICAL SOCIETY, OF LOUISVILLE.

*Stated Meeting, Sept. 12th, 1892.*

THE PRESIDENT, Dr. A. M. Cartledge, in the Chair.

### SYPHILITIC CASES.

DR. I. N. BLOOM: I simply want to exhibit this patient to illustrate a point that has been very much misunderstood; at least the syphilid has been called by various names. There seems to have been a great deal of confusion between the forms of syphilis known as serpiginous and tuberculous. There is really no such thing as a tuberculous syphilide. The term is applied to a form, rarely met with, a type of which is shown in Kaposi's atlas. This patient gives the history of syphilitic trouble of three or four years standing.

The infiltration all around the orifice of the anus and perineum is that of condylomata lata.

No. 2. This little colored girl came to me on the second day of August last, and I made diagnosis immediately after seeing the lesion on the cheek; it has since been confirmed. When she consulted me there was this induration which you see on the cheek, and a few enlarged glands on the neck, nothing else. I made a diagnosis of syphilis from the initial lesion on the cheek. She gave the history that some time before she had a fight with another colored woman and was bitten on the cheek. I gave her powdered chalk, bread pills and other things to hold her, continuing this treatment for three weeks, when the eruption appeared on her body, making the diagnosis absolutely certain. She was not put upon specific treatment until after the eruption appeared. The date of her altercation preceded the appearance of the local lesion about four weeks, or two months before I saw her. It would be an interesting case if we could make an examination of the woman who bit the girl, I doubt not we would find decided evidences of buccal syphilide. We made every effort, but could not find her assailant. This is the first chancre that I have ever seen on the cheek, but they have been reported not infrequently. There is still considerable enlargement of the glands of the neck, but the induration of the cheek has grown less and less since she

first commenced specific treatment, a little less than a month ago. There has been no enlargement of the glands in the groin.

It seems to me this is a perfectly clear case of syphilitic lesion; girl, eighteen years of age, otherwise seemingly in excellent health; does not claim to have been virtuous, but as far as she knows, has not been exposed to any disease through coitus. There appears, some time after a bite, a sore on her cheek, which is a painless, indurated, non-ulcerative enlargement, and, in addition to this, a very great induration of the glands of the neck. I am consulted two months after she was bitten, and, in three weeks send her to the hospital, at which time the enlargement of the glands and the syphilide on the cheek were twice as large as they are at the present time. The glands on the neck were enormous, so large that you could see them as far as you could distinguish her features, on both sides of the neck, but larger on the side on which the chancre appears on the cheek. Before being sent to the hospital, she came to see me every two or three days, and I was constantly watching for an outbreak upon the body. I attended her at the hospital. I told her that such a breaking out would occur eventually, and it did occur. It was followed by scabby sores on the head and condylomata upon the genitals, both larger labia being involved. This condition of things led me to put her upon specific treatment, which has caused a disappearance of the indurated condition to a great extent. The history, it would seem to me, excludes anything else but syphilis, and makes it as a clear case as is possible, without confrontation.

#### DISCUSSION.

DR. J. G. CECIL: I cannot but agree with Dr. Bloom in his diagnosis of this case; I think, according to his statements, there can be no reasonable doubt about it. I should be very much pleased if we could get hold of the other party in the case.

DR. E. R. PALMER: I really do not know that I have anything to say regarding the case: (Second case exhibited by Dr. Bloom). The condition of the local sore now is absolutely negative. In the local sore I cannot conceive any feature of syphilis, either early or late so far as any initial lesion is concerned, but the woman is undoubtedly syphilitic. I see so few

colored people, and of course they are often seen by Dr. Bloom in his hospital service. The condition of the glandular enlargement is such that this alone would not justify anything in the diagnosis of syphilis. Except for my entire confidence in Dr. Bloom's ability to make a diagnosis, I would not be prepared to say that the scar on the cheek was a chancre, but I recognize the extreme possibility of the occurrence of chancre anywhere, where the infection might be applied, and, in view of the history of the case, I think there is no reasonable doubt but that this is the initial lesion. The mastoid glands are not enlarged on either side as far as I can determine now. In fact, the case is a little too far along to make any positive diagnosis, except on the history. Dr. Bloom's history of the case, I think, makes it perfectly clear that the initial lesion occurred at that point, (on the cheek), but I must say that in the sore, as I see it now, there is no physical evidence of its being a chancre. We all know the tendency to strumous trouble in colored people, and their liability to symmetrical adenitis. While this patient has shown secondary manifestations for three months, and been under treatment, no Doctor has the right to say that it is or is not syphilis, just from the case as it presents to-day. I think the day is not far distant when syphilis will be taken from the class known as venereal diseases.

DR. I. N. BLOOM: I think it all points to infection of recent date.

DR. E. R. PALMER: It is unquestionably infection of recent date. I think I can quote Dr. Bloom when I say that it is exceedingly hard to find a vaginal initial lesion. Dr. Bloom has shown me one or two cases of local vaginal lesion, and Dr. Bullock brought in a case some time ago with a chancre on the labium minus. It is exceedingly hard to find the local lesion in the female.

DR. I. N. BLOOM: I want to indorse what Dr. Palmer has said, that in the woman you often find evidences of recent syphilis where there is no evidence of the initial lesion. As a case in point, I will mention a girl whose history I knew very well, knew also that she had not led a virtuous life. A man had been sent to me suffering from iritis; he had been treated but received no benefit; he denied absolutely having had a sore of any kind. Upon examination (he having come



directly from the oculist), I found a few scabs in the hair; found syphilide on his body; found a mucus patch in the corner of his lip; he had this iritis and a universal glandular enlargement. He told me that he had had no intercourse with any woman, except one, since Easter day. In my absence, my assistant examined the girl, and found absolutely nothing. Not knowing who the girl was and feeling as I suppose all doctors do, that they are not thoroughly satisfied unless they make an examination themselves, I requested this man to bring the girl to my office that I might make a personal examination. This was done and much to my surprise I found it was the girl above referred to, whom I knew very well. I made a thorough examination and could find no trace of syphilis of any kind whatever. The man had no chancre as far as I knew, but he had unmistakable evidences of syphilis. I do not know where the syphilitic virus entered, but there was no doubt as to the presence of syphilis. Another case I recall came to me with diagnosis of cancer of the tongue, and yielded promptly to six months' mixed treatment; that is, all traces of it disappeared. In this case there was absolutely no history of chancre, but it was unquestionable syphilis.

Dr. Anderson will remember a case that I sent to him on one occasion, a young man; I made the diagnosis, yet I know it was syphilitic trouble. The man died of typhoid fever about six months after Dr. Anderson saw him. I do not doubt that there are many men who are perfectly honest in saying that they have never had a sore, yet, there are unmistakable evidences of their having syphilis. In women I believe that more chancres are overlooked than discovered.

In the second case reported by me, I think the sore is a typical induration and can only be attributable to one cause, syphilis. I think a chancre can be of the Hunterian type on the cheek as well as on the penis. Concerning the enlarged glands of the neck—we would naturally expect a greater enlargement on the side on which the chancre is situated. Glandular enlargement is produced through the lymphatic system, and I believe, if Dr. Palmer will think a moment, he will remember a case we saw together having a severe

chancre on the penis on one side, and the enlargement in the groin on that side was very much out of proportion, very much larger, than the glandular enlargement on the other side of the groin. Referring again to the case under discussion, I do not see what the sore on the cheek could be except chancre; I would have nothing else to suggest. I do not see what could produce that form of induration which is left. Taking the case just as it appears now without any history, without any syphilide on the body, without any history of the effect of the mercurial treatment, simply the sore on the cheek and the glandular enlargement, I think the suggestion would be initial lesion. It does not look like eczema or any form of furuncle, or, in fact, anything except chancre; there has never been any sensitiveness or evidence of pain on pressure. The simple existence of these two conditions—the enlargement of the glands, and induration on the cheek I think suggest syphilis. I agree with Dr. Palmer that the day is probably not far distant when syphilis will be taken out of the class known as exclusively venereal diseases.

DR. A. M. CARTLEDGE: I believe this is a case of syphilis with the initial lesion on the cheek. However, I do not know whether I would have been inclined to consider it syphilitic trouble, had not Dr. Bloom given us the history in detail.

#### FIBROID TUMOR.

DR. TURNER ANDERSON: I present here a sub-mucous fibroid tumor removed from a woman thirty-four years of age, who had been in the care of an irregular practitioner who made diagnosis of pregnancy; the patient was a widow and about as far above suspicion as possible. Upon examination I found this tumor which was removed without great difficulty, promptly relieving the case. The tumor was found beneath the mucous membrane and was without a pedicle. I secured it with a pair of forceps, pulling it down as low as possible, separating the adhesions with my finger, believing this to be the safest way. There was continuous hemorrhage for several weeks before I saw the patient, none afterward.

#### TRAUMATIC ANEURISM OF CHEEK.

DR. W. O. ROBERTS: At the annual

meeting of the Medico-Chirurgical Society during the spring, Dr. Anderson exhibited a patient (little girl) suffering from traumatic aneurism of the cheek. The history of the case was about as follows: When the child was seven years old she was struck on the cheek with a stick, a swelling immediately raised and never disappeared. At the time the patient was exhibited which was seven years after receipt of the injury, those of you who saw the case will remember the strong pulsation of the tumor, and the thinness of the tissues superficial to it. Compression of the anterior temporal artery would cut off pulsation of the tumor. It was advised by the surgeons present at the meeting that an early operation should be performed, otherwise the tumor would increase in size, and eventually the skin would give way. I saw the case with Dr. Anderson last Thursday at the St. Mary and Elizabeth Hospital; found the growth had considerably increased in size, there was also a dilated condition of the smaller vessels on the surface extending some distance beyond the tumor itself. The skin the growth was very thin and bluish in appearance. An operation was performed at once, Dr. Butler administering the chloroform, Drs. Anderson and Bullock assisting. I made a long incision directly over the central portion of the tumor and carefully dissected it out. I think there were eight vessels ligated; hæmorrhage very slight, and the patient has done uninterruptedly well since the operation.

#### SPECIMENS.

DR. W. C. DUGAN: I have three specimens to exhibit: No. 1. Sarcoma of the kidney, removed on the 16th of last month at the Children's Hospital. A day or two before the operation the patient was brought in from the country by Dr. Durrett for some obscure abdominal troubles, and upon examination we found in the side a large tumor extending under the costal cartilage and into the pelvis. Diagnosis of cancer of the kidney was made, and operation advised at once. Drs. Cartledge and Vance saw the patient and both agreed not only as to the diagnosis, but also as to the advisability of immediate operation. Operation was performed on August 16th, Drs. Vance and Cartledge assisting. I made an incision extending from the eighth rib down over Poupart's

ligament, removing the tumor and a portion of the surrounding tissue, after ligating the pedicle; there was practically no hæmorrhage and no drainage tube was used; patient on the table about sixteen minutes. The patient was troubled at the time of operation with malarial fever, temperature 100.2° F., pulse 126 when she was put upon the table. I believe we made a mistake in operation on this patient when we did, and if I had it to do over again, I would put her on treatment for malarial fever for a number of days before submitting her to operation. After the operation her temperature went up to 103° and pulse to 166; however, she has done fairly well since, leaving the hospital on the twentieth day. Since her return home she has gained flesh and strength and is able to run and play as other children.

Specimen No. 2—This specimen is one of especial interest; it is the entire appendix, and I call particular attention to the shape of it, it was just as you see it when removed. The patient, I regret to say, died. On the 16th day of August I was called down near Jellico to see a young man suffering from what was supposed to be intussusception. I reached him on the 18th after forty miles jaunt over the mountains. I found the patient with pulse 110, very bad expression of the face, etc. Immediate operation was advised. He realized his condition as he had been vomiting fecal matter since the Sunday previous. It seems on the 11th of the month which was Thursday, he had a severe pain in the left side, which he attributed to having eaten a watermelon the day before. On Friday he was some better and able to sit up, but suffered pain and took an opiate. On Friday night a physician was called who made diagnosis of intussusception; vomiting was excessive and he had no movement of the bowels whatsoever. He continued to grow worse and on Sunday he had stercoraceous vomiting; then one of his physicians came to town for me and I went out with him. Drs. Glass and Dailey, of Boonville, had charge of the case, and ably assisted me in the operation. I opened the abdomen and passing my finger down to the cæcal region, this specimen was brought up, there being no adhesions at all; it looked very much like a large leech, and you can all see the resemblance. There was no hæmor-

rhage at all, and caecal attachment very small and shows that it has been made small by being twisted. The young man was in such condition as to require very rapid operation, so he was off the table and in bed in a very few minutes. Now, the pathology of this is especially interesting:—You will (the appendix being cut open) notice here a large clot of blood; he had ulceration of the appendix, opening into one of the large blood vessels, which resulted in a hæmorrhage into the lumen of the appendix, ballooning it as it were, and he had this peculiarly developed appendix, which finally became twisted causing obstruction and gangrene. This shows how little is required to cause complete intestinal obstruction, as in this case there was nothing else, yet there was complete obstruction which was relieved by its removal. I left him in about two hours, seeming to be doing well, but there was still a very bad expression about the face. He had two large fecal evacuations that evening and night, and cessation of vomiting, but died the next day at ten o'clock in collapse.

Specimen No. 3.—Next is an appendix removed from a patient who was under the care of Dr. F. C. Wilson. Dr. Wilson had made the diagnosis of appendicitis. There was no doubt about its being a case of appendicitis, as you will observe here an enterolith *en situ*. I was asked to see the case one week ago last Saturday by Dr. Wilson, and, upon examination, we found an induration in the right caecal region. At the time the patient's pulse ranged from 95 to 100, temperature practically normal. Now, we considered this one of the "border line" cases, and advised the little fellow to be left without operation until the next morning, provided the symptoms did not change for the worse, when we would see him again. He was given that night ten drops of the tincture of opium, which gave him a good night's rest. The next morning he felt well, but on examination the tumor in the caecal region was still marked, so we decided to delay operation no longer. There was little or no rise of temperature in this case at any time. I want to say that the doctor in this case had suspected cystitis at first, and had treated him for this condition, but upon examination, the urine was found to be perfectly normal. The patient was put upon the table and an

incision made from middle of Poupart's ligament toward the anterior spinous process, hoping to find the pus or abscess extra-peritoneal. Doctor Kirk assisted in the operation; the peritoneum was separated from the iliac fossa which being opened and finding no pus the peritoneum which was much congested and rather protruded into the wound was opened, and to our surprise found a great deal of pus.

The patient had general suppurative peritonitis, there were a great many patches of lymph of a dirty gray color on the cecum, and the whole peritoneum presenting that peculiar dirty-gray appearance which we so often find in suppurative peritonitis. The cavity was thoroughly washed with hot water, and then the right caecal region loosely tamponed with iodoform gauze. The operation lasted about twenty to twenty-five minutes. He was taken off the table in good condition apparently, having lost nothing by the operation; he remained so all that day, and had a very fair night up to twelve o'clock when there was considerable distension of the bowels. I saw him again at five o'clock at which time there was decided tympany. We introduced a tube into the stomach and relieved him of much gas and tried rectal injection of turpentine emulsion, salts and water etc., but septic paresis was profound and he grew rapidly worse, while the discharge from the wound was perfectly sweet. Patient died about six o'clock. The bowels were enormously distended, and we were unable to get anything through his stomach at all.

In the two cases reported, one had decided tympany, the other case no tympany at all. This makes eight cases of appendicitis I have had in the last two months, four of which have been fatal, making the mortality fifty per cent.

If an individual experience is to be relied on, I am justified in coming to the following conclusions: First. The symptoms of appendicitis are variable and misleading, often times simulating cystitis, intussusception, internal strangulation, etc.

Second. The localized pain, "McBurney Point," is often absent. I am convinced that that symptom has been dangerously magnified. Many regard it as almost pathognomonic, and when not found, cases of appendicitis are left to the mercy of



accident and allowed to drift beyond the safety line before counsel is called.

Third. The sudden onset of an attack of severe colic, in the young, which does not yield in a few hours to medicinal agents should excite strong suspicion of appendicitis, and cause the physician to call to his assistance a surgeon and thereafter see the case together as often as it be considered necessary.

Fourth. I desire to place myself on record as most decidedly opposing the position of Drs. Loomis, Draper and Delifield in maintaining that these cases are medical, and should be under the absolute control of the physician, he saying when the surgeon is to operate.

Fifth. The first duty of the attending physician when he suspects appendicitis is to call a surgeon, for if he waits for the "beginning of sepsis or shock," or signs of perforation, etc., etc., he had almost as well not call him at all. If the physician waits until he considers an operation necessary, oftentimes he has delayed too long, and, too, it is always desirable that the surgeon become somewhat acquainted with his patient's temperament, etc., before the operation.

Sixth. The presence or absence of temperature is of little or no significance. It is not unusual to find large accumulations of pus with sub-normal temperature in these cases—a fact not generally appreciated. If every case of appendicitis, catarrhal or suppurative, were subjected to early radical operation, fewer deaths, by far, would result than under the present method of so-called conservative treatment. No stronger argument could be produced in favor of early operation than our inability to examine an abdomen and say what condition exists within, and the high rate of mortality in these cases, if left to medical treatment alone. Some of the most severe cases, to judge from the subjective symptoms, prove to be nothing more than an intensely congested appendix, whereas, some of the mild, "comparatively" safe and "comfortable" cases, were found to be diffuse, suppurative peritonitis, with perforation; therefore, I maintain that since we are unable to diagnose the condition, and since exploratory operation under favorable surroundings, and in skilled hands, is not dangerous, I desire to enter a plea for early operation.

#### SPECIMENS.

DR. W. L. RODMAN: The specimens you see here are several enlarged glands that I removed from the left inguinal region of a man about thirty years of age, a few days ago. The enlargement of these glands followed an attack of gonorrhoea: they were easily dissected out, and I did it almost entirely with my finger. The wound was thoroughly washed with 1 to 500 chloride of zinc solution, the patient being up and around the hospital in three or four days. There was not a drop of pus. I consider extirpation decidedly the best plan of treatment for these enlarged glands, and have been doing the operation for several years, with excellent results.

No. 2.—Here are two sections of veins, each of them taken from patients suffering from varicocele. The bloody one was removed to-day, and was the most extensive varicocele that I have ever seen. I brought the ends of the veins together by means of a continuous buried suture, finally closing the wound, also with continued suture, without drainage. There was not a drop of pus, and I think the result will be all that could possibly be hoped for.

DR. H. H. GRANT: What do you want to bring the ends of the veins together for?

DR. W. L. RODMAN: For the purpose of holding the testicle up.

#### TETANUS DUE TO PUNCTURE WITH A HYPODERMIC NEEDLE.

An instructive case is reported in a recent number of the *British Medical Journal*. A patient who had been in the habit of injecting morphine hypodermically into himself came under observation with symptoms of tetanus which eventually resulted in death. A careful search revealed no other cause for the tetanus than a small inflamed and suppurating place near the shoulder, which had been caused by one of the hypodermic injections he had given himself. The lesson taught by this case of the importance of the observance of scrupulous cleanliness, even in so small an operation as a hypodermic injection, cannot be too strongly impressed, and the memory of the disastrous effects which may result from the neglect of proper precautions should be firmly fixed in the mind of every practitioner.—*Omaha Clinic*.

## Translations.\*

By M. B. WERNER, M. D.

Death ending from Acute Mercurial Poisoning, due to the Local Application of the Grey Salve (*Berlin. Klin. Woch.*, 1892).—Jan. 15. Female, æt. 20, suffering from cracks in hands and pain in the forearm, was advised to use the salve. One hour after its local application nausea, faintness, and vomiting set in. Admitted on the same evening to the hospital at Breslau; vomiting continued, repeated fainting attacks, hand and lower third of forearm swollen, doubtful fluctuation; incision shows cellulitis. Jan. 16. Vomiting continues; albuminuria, tenismus; evening temp. 36.6°. Jan. 17. Bloody stools, colic, anuria; temp. 36.2°. Jan. 18. Hæmatemesis; continuous bloody stools. Jan. 19. Gangrenous gingivitis; anuria continues. Jan. 20. Death. Section the lower portion of the small intestine—hemorrhagic spots; superficial necrosis of the mucus membrane; the large intestine showed the grave picture of dysentery; kidneys showed necrosis of epithelium. The cause given for this grave train of symptoms, following only one application, is that it was applied on the broken surface.

Albuminuria during Pregnancy Treated by Internal Administration of Chloroform.—Duff (*Med. Neuigk.*, Sept. 17, 1892) reports the satisfactory results in five cases of marked albuminuria accompanied with convulsions. He gave in solution 0.8 gr. every hour; the convulsions ceased in a few hours and the secretion of urine increased. All were able to go to the end of their term, and in all the albuminuria disappeared after parturition.

Ballay and Lerefait (*Med. Neuigk.*, Aug. 1892) have treated whooping cough for months with creosote with surprising good results. In thirty cases Lerefait asserts that the most grave cases lasted never longer than six weeks, and usually only one or two weeks. Its first effect is to arrest the vomiting, and the number of attacks of coughing are reduced from six-

teen and eighteen to three and four daily. It is given in syrup:

**R** Creosote..... 0.50  
Syrup..... 100.  
M. S.—Two to three teaspoonfuls in children six weeks to two months, six to eight teaspoonfuls as they are older.

Ballay adds wine to the mixture.

Treatment of Tuberculosis of the Lungs by Antiseptic Inhalations.—Delthil (*Med. Neuigk.*, Sept. 24, 1892) reported before the Académie de Médecin his method, by which he claims a marked improvement and prolongation of life:

**R** Ol. terebinth..... 250.0  
Ol. lavandul..... 100.0  
Iodoform..... 10.0  
Sulph. ether..... 30.0 M.

This mixture, impregnated with the air breathed, will reduce the quantity of tubercle bacilli, and even changes their appearance under the microscope from their normal comma to olive-shaped in the space of five to ten days.

## GONORRHOÆAL VULVO-VAGINITIS IN YOUNG GIRLS.

Epstein (*Abst. in Centralblatt f. Chirurgie*, 26, '92) has observed gonorrhœal vulvo-vaginitis in newly born infants, in whom it should be distinguished from the discharge produced by the desquamation from the vagina, which occurs in the first few days after birth. This latter sometimes has the appearance of pus, but the microscope shows it to be made up of epithelial cells. Through neglect of cleanliness, however, this desquamative catarrh can lead to a real purulent, though non-specific vaginitis. The gonorrhœal infection of the genitals of baby girls probably occurs in the same way as that of the eyes, namely, during the passage of the child through the cervix and the vagina. Epstein believes that this occurs more frequently than is commonly supposed, and that a part, at least, of the cases of gonorrhœal vaginitis in somewhat older girls are the result of an overlooked and neglected infection at birth. [For the difficulty in tracing the origin of these infections in young girls we can vouch from personal experience, and for some of them Epstein's theory may hold; in general, however, the precocious small boy and hired-man theories seem more plausible.] Epstein makes the reasonable suggestion that with gonorrhœal mothers, care should be taken to prevent infection of the infant's vulva as well as the eyes.—*Omaha Clinic.*

\*Translated for MEDICAL AND SURGICAL REPORTER.

## Bacteriological Notes.\*

**ETIOLOGY AND TREATMENT OF TETANUS:**—In the *Transactions of the International Medical Congress, 1891*, Sig. Sormani presents some very interesting facts concerning the distribution of the tetanus bacilli and the effect produced upon their virulence in passing through the intestinal tract of animals. The tetanus bacillus exist in the upper layers of the soil, especially where it has been manured or infected. By rolling on the ground and subsequently licking their bodies, dogs and other animals introduce the bacilli into their alimentary canal and later deposit them again in the feces. The very interesting statement is made that the virulence of the bacteria becomes diminished in the gastric juices and afterwards resume their virulence in the intestine. If animals are withheld from any exposure to fresh infection, their feces will remain virulent for a considerable time. Rabbits have been infected with tetanus from the feces of dogs that had been confined for sixteen days. Tetanus bacilli invading the respiratory tract do not infect unless they are able to penetrate the tissues. Most cases of this disease have been acquired by wounds becoming infected by manured earth. As tetanus bacilli are extremely resistant to the ordinary disinfecting solutions, and are only destroyed with rapidity by iodoform and an acidulated solution of corrosive sublimate, the treatment should be to scrape the wound and after washing thoroughly with the antiseptic solution sprinkle it with iodoform. Although the article contains little not heretofore known, it is suggestive in the direction of prophylaxis.

**A GAS-PRODUCING BACILLUS** (*Bacillus aero gener capsulatus* Nov. Spec.) capable of rapid development in the blood vessels after death:—Welch and Nuttall (*Bulletin of Johns Hopkins Hospital*, VIII, 1892, p. 81) describe a bacillus which they found in the blood of a man who died in the hospital in Oct. 1891. This bacillus is of considerable interest as it multiplies in the blood very rapidly (after death) and produces a large quantity of gas. It thus explains the cause of the occasional appearance of gas in the blood-vessels after death

which could not be satisfactorily attributed to post-mortem decomposition. Cover-glass preparations made from heart's blood and properly stained showed a large number of bacilli; from three to five micromillimeters in length and about the thickness of anthrax bacilli, with ends slightly rounded but sometimes almost square cut. The bacillus is not motile; capsules were sometimes observed about the bacteria. The bacillus grew on all of the ordinary culture media. It grew best at a temperature of 35° to 37° C. It is anaerobic. No growth took place in plain or sugar agar without first removing the oxygen. It forms no spores; the vitality of the cultures was of variable duration. It was destroyed in bouillon cultures heated to 58° C. for ten minutes. From inoculation experiments on rabbits the authors do not consider this bacillus as pathogenic for healthy rabbits under ordinary conditions. Rabbits were inoculated with certain quantities of a bouillon culture in the ear vein, killed after from two to five minutes and placed in an incubator. In the short space of six hours after death gas and bacilli had developed, the latter in enormous numbers.

**PRESERVING THE MALARIA PARASITE ALIVE.**—Rosenbach (*Berlin klin. Wochenschrift*, No. 35, 1891) calls attention to the fact that the plasmodia which produces malarial fever can be preserved in the living condition in the blood extracted by leeches. In a case of typical tertiary ague the author placed a leech over the spleen. It died in 48 hours and within it numerous dead plasmodia were found. Two other leeches were applied some hours before the beginning of the attack; one of these was opened in 24 hours and found to contain a very large quantity of red blood corpuscles, a large portion of which included living plasmodia and mobile pigment. The other leech was opened in 48 hours. It presented a similar condition. A leech applied 24 hours after the treatment with quinine was found to contain a few shrunken organisms. From these facts the author suggests that human blood rendered artificially coagulable by each subtraction might be used for a cultivative medium for malaria parasites.

**SPORELESS ANTHRAX.**—In 1873 it was demonstrated that anthrax bacilli culti-

\* Translated for THE MEDICAL AND SURGICAL REPORTER.



vated in bouillon containing 1-2000 of bichromate of potash lost their faculty of producing spores. Their virulence, however, was not changed. Roux (*Annal. l'Institute Pasteur* 1890, p. 25.) has more recently produced a similar condition by the use of carbolic acid. His experiment briefly stated is as follows: ten test tubes containing bouillon to which carbolic acid had been added in variable quantities from 0.02 to 0.20 per cent. After sterilization they were inoculated with anthrax and placed in an incubator. The tube containing the greatest quantity of the acid remained clear, that containing the least developed bacilli with spores while those containing the intermediate quantity of carbolic acid developed sporeless anthrax bacilli.

The result of this experiment is important in illustrating the physiological and morphological aberrations in certain bacteria. It points still further to the effect that may be produced upon ordinary intestinal bacteria when their environment is changed either by medicines or an inflammation of the intestinal mucosa. It also indicates that changes in the environment of bacteria may endow them with characters, morphological and otherwise, which will separate them from the standard by which they are recognized.

#### EPILEPSY MISTAKEN FOR URÆMIC CONVULSIONS.

After reporting two cases of epilepsy with albuminuria, mistaken for uræmic convulsions, Dr. James Tyson says: (*Medical News*), that so far as any peculiarity of the convulsions themselves is concerned, there is no way of avoiding errors. The uræmic are in fact typical epileptic convulsions exhibiting the same varieties and degrees. But true uræmic convulsions do not repeat themselves at intervals of months or years at a time, and yet leave the patient apparently no worse for his experience. And if true epileptic convulsions happened to be accompanied by albuminuria, such albuminuria does not as a rule remain at a standstill, or grow gradually less, but increases, and is associated after a time with other phenomena of chronic Bright's disease, such as hypertrophy of left ventricle, œdema, and high vascular tension.

## Abstracts.

### DENTITION IN INFANTS.

Upon the questions of difficult dentition and gum lancing, the medical world has been for some years divided; the smaller party taking the modern view that dentition is a normal process and rare y if ever produces dangerous symptoms; the larger party holding that dentition is responsible for most of the ills that infants suffer from, and that gum lancing is its sovereign remedy.

It is undeniable that at the period in life when dentition is in progress, the infant is subject to certain disorders which occur much more commonly than at any other period of life.

We think it can be said, however, without fear of contradiction, that there is not a single positive observation which has ever been recorded to prove that dentition produces general or reflex symptoms.

If it could be shown that dentition was the only peculiar condition of the infant, then its causative influence would be clear. But dentition is not the only peculiarity and coexisting phenomena can only be classed as coincident. The most profound characteristic of infancy is that it is the period of most rapid growth and development of all organs; and careful observation of infants reveals numerous and great deviations from the normal growth and development in many instances. It will probably not be denied that such deviations are found most commonly in infants who have been artificially fed. In infants improperly fed, and this term is too extensive to attempt to define here, reflex manifestations are very readily produced, and it is not improbable that even a normally developing tooth may, in such an infant, be the exciting cause of trouble. We have seen infants, who would invariably have a bronchial attack immediately before the prurption of a tooth, but they have invariably been infants who were suffering from demonstrable deviations from normal nutrition. We have further found that after improving the nutrition of these infants, the further progress of dentition was unaccompanied by symptoms.

In such cases while it would be just as well perhaps to recognize the possible influence of dentition, its subordinate impor-

tance should be kept clearly in view. The great danger of teething is in the diagnosis, for when this is once made the important underlying conditions are apt to be neglected, and permitted to progress to the death of the child.

Dentition is a convenient scapegoat, and Olliver has well said: "During the nearly ten years that I have been connected with the Hospital for Sick Children, it has often happened that children brought to me for diseases of this type (teething) have been found to be suffering with an altogether different affection. It is very easy to invoke this diagnosis, but by passing in review the different organs and apparatuses, the diagnosis can easily be rectified."

But if dentition cannot be shown to be the great etiological factor of infantile disorders, it does not follow that gum lancing should be abandoned. It is difficult to overlook the numerous instances in which careful observers have thought they have obtained good results from its use, but it would be well also to bear in mind the many cases in which it has failed. As a therapeutic procedure it may have some value, but the indications for its use must be sought elsewhere than in a supposititious condition of teething. We should like to offer the following conclusions:

1. Before the diagnosis of "teething" is made, there should first be carefully excluded, organic diseases of all organs, infection, intoxication, and perversion of nutrition.

2. Gum lancing as a therapeutic measure should stand on its own merits, and be studied apart from any supposititious and undemonstrable process of teething.—*Journal Amer. Med. Ass'n.*

#### ICHTHYOL IN DISEASES OF WOMEN.

Drs. Roitman and Schönauer experimented with ichthyol in acute and chronic inflammatory diseases of the uterus and its appendages, and are quite satisfied with its efficaciousness. They tried it with success in parametritis, pelveoperitonitis, oöphoritis, salpingitis, periöphoritis, perisalpingitis, as well as retrouterine and periuterine exudates, chronic metritis and cervical erosions. The following formula was used:

**R** Ammon. sulpho-ichthyol..... 5 jlas.  
Glycerin..... f 3 ij.  
Sig.—For external application.

—*Zeitschrift für Therapie*, No. 18, 1890.

#### THE TREATMENT OF ALCOHOLISM BY DRUGS.

The *British Medical Journal* makes some excellent points in noticing a recent work upon this subject by Dr. J. E. Usher, of Melbourne. No one drug is regarded as a specific. Each case must be studied by itself, and such measures adopted as are especially adapted for its peculiarities. The author regards it of the first importance that the patient have a real desire to be cured. No treatment can succeed without the existence of this desire; hence the first thing must always be the strengthening of such will-power as the patient may possess. Harshness, threats, and abstraction of sympathy are all out of place in such cases. Dr. Usher for four or five days gives *nux vomica*; at night he gives bromide of potassium or some other sedative, if needed for sleeplessness. He thinks that the best hypnotic is hyoscine, given hypodermatically in doses ranging from one one-hundred and-fiftieth of a grain upwards. If absolutely necessary, one ounce daily of whiskey or brandy may be given. After the fifth day a mixture of manganese and strychnia is indicated for two or three weeks. Iron is given when a tonic is called for. Euonymin with pepsin is found needful when hepatic symptoms are prominent.

The nitrate of strychnia is used hypodermatically by many close observers. With it is combined, sometimes, atropine. Often a mixture of tinctures of cinchona and iron appeases the appetite for drink.

In general, the first object sought is the breaking of the vicious habit; and, second the neutralizing of the immediate ill effects which may follow the dropping of the accustomed stimulus. The first end can be obtained only by a determined effort of the patient's own will. Drugs may be of service here in making him so sick that he cannot enjoy the use of alcohol; in doing this care must be taken that drugs be not used which endanger the patient's health or life. The use of strychnia as a substitute for the alcoholic stimulant to which the nervous system has become accustomed, has a rational basis. The use of morphine, cocaine, etc., may be beneficial under certain circumstances, but is fraught with the danger that a new habit may be formed worse than alcoholism.

The *Journal*, however, relies not so much upon drugs as upon the diffusion of knowledge, well directed legislation, and improvement of the lives of the people so that they may not crave drink to overcome the discomforts of bad digestion and the worries and anxieties of daily life.

#### CASE OF HYDRAMNION IN TWIN PREGNANCY.

Dr. Everett J. Brown, in *North American Practitioner*, Sept., 1892, records a case of a patient *æt.* 34, mother of two children, youngest seven years of age.

Physical examination revealed an enormous abdomen, *œdema* of feet and hands, body temperature 102° F.

Vaginal examination revealed the cervix completely dilated, the finger coming in contact with a very tense bag of water. The membranes were ruptured, and was followed by an astonishing gush of water. He estimated, that at least eight quarts was passed; the relief to patient was immediate. Regular labor pains began, and were soon followed by the birth of two *fœtuses*, weighing two and three pounds. There was only one placenta, both children were females and were probably unioval twins. The puerperium was uneventful, the patient being up in nine days.

All *œdema* of extremities disappeared.

#### TWENTY-FIVE CASES OF EXTIRPATION OF THE UTERUS FOR CANCER.—A CONSIDERATION OF ULTIMATE RESULTS.

Dr. Charles A. L. Reed, of Cincinnati, presented to the recent meeting of the American Association of Obstetricians and Gynecologists, a report of twenty-five cases of complete vaginal extirpation of the womb for cancer with only two primary deaths—one from shock and one from iodoform poisoning. Of the twenty-five operated upon, but fourteen were of more than two years standing, and hence were all that could be discussed with reference to their ultimate results. These fourteen were divided into two classes, of seven each *viz.*, those in which the disease had existed for more than six months before the operation and those in which it had existed for less than six months before

the operation. Of the first class, *i. e.*, those of more than six months (an average of 10 months) previous duration, all were dead; of the second class, *i. e.*, those of less than six months (an average of 4 months) previous duration, only one had since died. One of the recoveries is of more than five years duration. The conclusion from these figures is that the cases of cancer of the uterus ought to be remanded for operation as soon as diagnosed. Dr. Reed looks upon total extirpation as the only operation to be advised or practiced in these cases, the primary mortality from which, in experienced hands, varies from five to eight per cent.

#### SOME PRACTICAL POINTS IN THERAPEUTICS.\*

By JNO. A. LARRABE, M. D.,  
LOUISVILLE, KY.

The author, in conclusion, made mention of those therapeutic agents which, during the summer months, had been so successful, in his hands. In enterocolitic diarrhoea—the so called “summer complaint” of cities, dependent upon the various micro-organisms, vitiated air, and bad food—salol, naphthaline, carbolic acid calomel, in minute doses, and nitrate of silver stood the test.

In gastro-enteritis, he found salicylate of bismuth useful and in inflammatory diarrhoeas of infants and older children Rochelle and Epsom salts, in acid infusion of roses with small doses of laudanum. In chronic cases, the nitrous acid camphor mixt. (Hope's) did not fail. For gastric fevers so common in children the preparations, ammonia-phenique, and sulpho-phenique, were used with better success than any other treatment.

He also used this treatment very satisfactorily in the exanthemata.

In diphtheria, peroxide of hydrogen and whiskey internally gave him the best results. Disappointment in the use of the peroxide, is often due to the poor quality of the drug. It is a very unstable article. It should always be purchased in small amounts protected from the light, by being put up in 4oz bottles. On coming in

\*Abstract of a paper read before the Louisville Medico-Chirurgical Society.



contact with the false membrane of the throat, a white foamy reaction takes place. It should be freely applied to the throat on mops or by use of spray. The crying and resistance of the child, favors the distribution of the fluid. In this way the author has treated successfully a great many cases of diphtheria. He believes that the symptomatic use of definite, although often toxic, doses of whiskey, in children even of tender age, to be the surest safe-guard against heart failure.

### Selected Formulæ.

#### CORYZA, CEPHALALGIA AND ASTHMA.

Dr. Coupard (*Münchener med. Wochenschrift*, No. 12, 1892) recommends in asthma, coryza and cephalalgia the following powders:

<b>R</b>	Cocaine hydrochlorate.....	grs. ij.
	Menthol.....	grs. iv.
	Boric acid.....	grs. xxx.
	Finely powdered roasted coffee.....	grs. viij.

#### EXTEMPORANEOUS GLYCERIN SUPPOSITORIES.

M. Romer contributes the following to the *Pharmaceutische Post*:

<b>R</b>	Anhydrous sodium carbonate.....	1 gm.
	Stearin, rasped.....	grs. iv.
	Alcohol.....	15 "
	Glycerin, q. s. to make.....	80 "

Mix the sodium carbonate and stearin, and pour the alcohol over them. Heat the mixture in a water-bath until the alcohol is driven off, then add the glycerin and continue the heat until a limpid solution is obtained. Pour into molds. The quantity indicated is sufficient for four suppositories for adults.

#### THE TREATMENT OF SOFT GOITRE BY PARENCHYMATOUS INJECTIONS OF IODOFORM.

Prof. v. Mosetig-Moorhof (*Le Bulletin Médical*, No. 36, 1892) proposes parenchymatous injections of the two following solutions in the treatment of soft goitre:

<b>R</b>	Iodoform.....	1 gm.
	Ether.....	ss.
	Olive oil.....	7 gms.

<b>R</b>	Iodoform.....	1 gm.
	Ether.....	5 gms.
	Olive oil.....	9 gms.

The writer, however, has only used the former solution, and in sixteen cases treated by him (ten men and six women) the results were excellent. In two months the necks of all the patients had diminished six centimetres in circumference. Two months later this had attained eight or ten

centimetres. The goitres did not regain their former volume even six months after cessation of the injections. A syringe-full is injected into each goitre, and in one case of enormous goitre six grammes (13/4 drachms) were injected. This is repeated every four to six days; some of the patients received one each day for several days without any bad results. No disagreeable action was noticed.

#### CONTUSIONS OF THE SCALP.

Dr. F. F. Lawrence concludes as follows (*Columbus Med. Jour.*) on this subject:

1. Contusions of scalp caused by slight blows or falls, accompanied by moderate amount of effusion, are simple and require little treatment.

2. Contusions of scalp caused by sharp blows or severe falls are always to be examined carefully, and a guarded prognosis given.

3. Those accompanied by large effusions, and especially if pulsating, should be treated by shaving scalp, incising, turning out clots, (examining carefully the pericranium and skull), securing bleeding points, closing with sutures, preferably braided silk, dressed with dry antiseptic dressing, which should only be removed when absolutely necessary, before the fourth or fifth day, when sutures should be removed, a light compress bandage applied.

4. Those accompanied by little or no swelling, when caused by severe blows, should be carefully watched, and on first appearance of local fever or swelling, freely incised, washed out and treated as open wounds.

5. If the case is not seen until patient has had chills, hot dry skin, hard pulse, fever coated tongue, nausea or vomiting, insomnia, nervous twitchings, or any other symptoms of meningeal inflammation, we should cut down and trephine at once over site of injury.

6. While inflammation of either pericranium or the meninges, is one of the things likely to follow these injuries, it may be prevented by early incision.

7. Where caries of bone or meninges occurs, the cause may generally be found to be injury of pericranium, which became inflamed, effusion followed, then inflammation of vessels from pressure, and then by extension meningitis.—*Med. Review.*

# THE Medical and Surgical Reporter

ISSUED EVERY SATURDAY

EDITORIAL AND BUSINESS OFFICES:

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## THE MEDICAL AND SURGICAL REPORTER.

SATURDAY, OCTOBER 29TH, 1892.

### THE TREATMENT OF COMPLICATED FRACTURES.

The treatment of complicated fractures as advocated by v. Volkmann, is, that every complicated fracture should be operated upon primarily, the operation consisting in enlarging the wounded space, enough to admit the finger to search for and remove all loose fragments of bone, blood and clot. Should the fractured ends of the bone be sharp, they should be cut, provision for drainage should then be made.

Dr. R. v. Frey believing this method rather extreme, concluded to make some studies upon the results of antiseptic conservative treatment.

In the Grazer clinic all suitable cases were treated by the Volkmann method, with the result of slow healing often

marked shortening and pseudo-arthritis. These placed along side of cases sent in by country practitioners, in which the wound had been freely dusted with iodoform and bandaged, and which—after three or four days presented an aseptic condition—naturally created some doubts regarding the propriety of Volkmann's treatment.

The treatment now used at the above clinic is as follows: In the absence of much contusion to the soft parts, the wound is cleansed and disinfected, then powdered with iodoform, and dressed with iodoform and sublimate gauze.

If injury to the soft parts has deprived them of their vitality, such are removed, the wound washed out with sublimate solution, and if necessary, provision made for drainage.

Incision is only resorted to when there is reason to believe that foreign bodies have entered the wound, or the fracture has perforated into an articulation, or if symptoms of local infection present themselves.

As a rule bone sutures are not used; when, however, it becomes necessary, use such. Metal wire or Gussenbauer's clamps are used.

The author gives a list of forty-six cases: thirty by conservative treatment, sixteen non-conservative or by incision.

Among the conservative cases, there was one death from tetanus, one from phlegma; the remaining twenty-eight were cured, eighteen first intention, and in ten cases there was some suppuration owing to presence of sequestra.

Debridement was performed in nine non-septic and seven septic cases (cases were septic on admission.) Of the nine non-septic all recovered, notwithstanding one suffered from erysipelas; of the remaining eight there were five with slight, and one with marked suppuration; two without any. Among the seven septic cases there were four deaths (three from sepsis and one from tetanus). The remainder

recovered, one after secondary amputation, the other after long continued sequestra formation.

Of the thirty cases conservatively treated twenty-five were perfectly healed; in two, bony defects prevented a solid union; one tetanus case, and one case that left the hospital too soon, will bear evidence why the results were unsatisfactory.

Of the 9 non-septic cases treated by debridement, one healed with pseudo-arthritis, the remaining 8 entirely healed; of the 7 cases (septic) treated by debridement, 2 were perfectly healed, 4 died, and 1 had amputation performed.

It is interesting to note that the number of conservatively treated cases, show no greater percentage of wound infection than those in which incision, drainage, etc., had been used; further, that of these cases there was but one of pseudo-arthritis, and only in one-third of this number was there suppuration; whereas, in those cases where debridement was used this took place in one-half the number. There is also less shortening noticed in conservatively treated cases. The author concludes, therefore, that in the treatment of complicated fractures of the extremities, the rule should be conservative treatment; and the exception, debridement; the latter to be used only in special indications.

The destructive antiseptics should be only used when urgently called for; but in most cases it can be replaced by the conservative form of antiseptics.

#### UTERINE FIBROIDS.

Humans defines uterine fibroids as aggregations of normal uterine tissues in abnormal situations and masses. He says that operations are rarely, necessary, and among the indications for operations are hemorrhage when it threatens life, when unbearable from weight, when they cause serious pain and interfere with the digestion or circulation, obstruction of bowels, or when the pedicle becomes twisted.—*Brooklyn Medical Journal*.

### Book Reviews.

*Physician's "Complete" Book of Records*, edited and compiled by Samuel E. Walker, M. D., Philadelphia. Comprising Daily Call List, Daily and Monthly Cash Accounts, Obstetrical Record, etc., etc. Complete in one volume, bound in three-quarter Russia. Price, \$5.00. Keystone Publishing Co., Philadelphia.

No class of professional men lose as much money, through faulty bookkeeping, as physicians. The chief reason for this lies in the fact that nearly all account-books made for the use of physicians are either so complex as to be constantly neglected, or so subdivided into Call List, Cash Book, Ledger, etc., that a regular bookkeeper alone can keep up the postings. Probably not one practitioner in fifty keeps his accounts in such shape that he can tell any patient, at a moment's notice, exactly how his account stands. This is not because the accounts of an average physician are complicated or extensive, but is wholly due to the fact that, so far as we know, a simple and yet complete method has hitherto been unknown. There are a number of systems extant which possess many points of excellence, but nearly all fail to cover the ground completely.

The new method, presented by Dr. Walker, seems to meet all the requirements of the physician with an average practice, and, appears to merit its title, "Complete."

The great feature of Dr. Walker's book is the system of keeping the entire record of each patient for each month, on one line extending across two of the broad pages. The first entry is patient's name and address; then memoranda regarding case, and following this thirty-one columns for recording visits during month, conveniently divided into morning, afternoon and night. Continuing on opposite page is the cash account, providing for payments on each or any of the thirty-one days, total charges for month, total payments for month, balance due at end of month, and also for subsequent payments, and transfer to succeeding month, if this be necessary. The actual time required for keeping this account will probably be not more than ten seconds for each patient, of not more than ten minutes a day in the practice of the average physician. We can see two great advantages in this system, viz: the physi-



cians current practice is daily under his eye, and closely grouped, instead of being widely scattered through a large book, and therefore no one is likely to be "overlooked," and each and every entry, being an "original entry," will be accepted in evidence by any court in case of suit to recover. There is no "posting," and, from the nature of the case, each patient's account appears every day exactly as it stands, all in one place, and complete.

The Obstetrical Record is compact and comprehensive, meeting all requirements. The Record of Deaths and General Memoranda, together with the extensive double index, make up a volume that will give great satisfaction to the profession generally. The book is very substantially bound having the "patent back" device whereby each section is mounted on a linen guard, rendering the book practically indestructible. The low price is much in favor of the success of this new publication, which, we are sure, will meet with prompt recognition on its merits.

## Correspondence.

### AN EDUCATIONAL NEED.

*Editor of MED. AND SURG. REPORTER:*—Certain epochs have taken the lead in certain lines of progression—in greatly improving of literature and advancing particular sciences and arts nearer perfection. There are periods in which there is something more than natural or historical growth—where there are evidences of great leaps.

Medically and surgically we acknowledge our great debt to the genius of the generations that have preceded ours. We have no disposition to decry or quarrel with our inheritance. We cherish the lessons of many great problems solved for us. But from these problems new corollaries have been evolved to be worked out by our better light. Many of the old systems have had their day. With the advance of civilization, the increase of populations and the change of modes of life, new modifications are needed to meet new or better understood conditions. When we consider the progress that has been made—what generations have done—the problems mastered, the lessons learned, which we have no need of unlearning, we

have reason for the hope that we can do better than has yet been done. We are not ready to accept as fact that the processes of development and evolution in the medical and surgical profession have been worked out—that our science and art have reached completeness. The gratifying truth is that there has never been a time in the history of the profession when there was more vigor and intellectual activity than now, a very flood tide of high effort swells the veins of the profession. The question present and urgent is what lines can we adopt to hurry along our advances. The majority of the active and strong brained practitioners of every section of our country, of cities, rural towns and districts spend some time each year at some of our centres of medical and surgical education endeavoring to enlarge their professional knowledge in the clinics of our public and private hospitals. The spirit of inquiry and research is widespread. Only the *diluted mediocrity* of the profession is content with what is known. The desire pervades nearly the entire profession to gain more and better knowledge, familiarity with the more simple and accurate methods. By some cooperation, some organized plan, of our college and hospital authorities and our widely known clinicians and teachers, our visitors of the general profession would find much to tempt them into our midst. It is not possible to measure the great benefits that would accrue to post-graduates, to the general practitioners who visit the city for the purpose of improving their knowledge in general or in some specific line of practice, if the wards of our general and private hospitals were thrown open to them and they could be given the benefit of the bedside lessons and clinical teaching of our eminent teachers. We will not attempt to sketch a plan or mark out lines to be pursued; we will leave that to more competent hands. From the fact that the carrying out of some such idea as we have suggested would be in the interest of the entire profession and certainly in the interest of our medical colleges, the matter should command the attention of the profession. The men who visit us are not dull, but bright and earnest men, who come with an earnest purpose, and the only way we can perfect some plan to give them general and hospitable welcome and aid in promoting their educational plans is to begin.

Some plan certainly is possible in a great city famed for hospitality, philanthropic and educational systems. If a distinct institution could be so organized as to best serve the purpose that could be established. The enterprise would also have a commercial as well as a professional value, and thence of interest to the general business public. Nor are the social features, the widening of the fellowships of the profession, to be left out of consideration. The encouragements, strength gained by professional association, and the great benefits growing out of comparison of methods and results are not appreciated to the extent they should be. The interested association which promotes intimate acquaintance, softens professional antagonism and does much to drive out those vulgar jealousies which detract from the dignity of the profession. Such an institution in all its appointments and in its general management could be so conducted as to furnish an excellent theatre where could be brought into fellowship men of high character, talents and good work, many of national repute, both as specialists and general practitioners; where could be discussed those diseases which lie peculiarly within the field of medicine and as well those which by their very nature are without its domain and which require surgical means of investigation and surgical treatment. And there could be taught valuable lessons of guidance for those thrown in the narrower lines of professional life. One of the very certain and patent tendencies of such an institution would be to improve the teaching in our schools and draw to them the best talent of the country. As a rule the sons of our eminent physicians and surgeons and their students enter the medical school where their preceptors received their best lessons, they go where they are directed. If we would make Philadelphia a great center of medical and surgical education we must look to the influence of the general practitioners of the country. We must convince them that it is here that the best work is done and the best lessons taught. Then this free educational institution, blending with its work home and professional hospitalities would become a feeder for our best medical colleges. It would not draw from the schools but put better material in them, would have the healthful effect of relegating to the museums for stuffed animals the dudes who

would enter the profession, and put workers within their walls. It would be auxiliary to and contribute largely to elevate the standard of our organized system of medical education. Aside from its specific educational features, to such an institution there would be a home side appealing directly to home pride.

So manifold are the details of our medical science, so rich and varied its literature that the inviting and welcoming of general practitioners and specialists visiting our city into such an institution could not be otherwise than fruitful of much good. We would get the facts of many active and rich experiences, the history of new departures from old traditions and methods. Our period has impressed its characteristics upon our current medical literature; there is little of the ancient in its lines; it has in it the research, energy and noble genius of the living. With the old we are linked only by the tested truths of science and experience. Give to them who make our literature an arena in which they can discuss the results of their work. It is only those who *never knew much* who are *tired* of learning. There is a growing, vigorous life in the American physician and surgeon no matter what his location whether country side, barracks or prairie and he is willing to work hard and make many sacrifices to keep in the front rank of his profession. He has the good practical business sense to go where the best facilities are offered him to obtain what he feels that he needs.

JOSEPH PRICE, M. D.

Preston Retreat.

#### AMYL NITRITE FOR AFTER-PAINS.

I am satisfied that in many cases a nice warm meal is better than any medicine. Still, I have had several cases in which the pains were exhaustingly severe, and in which I was glad to turn to nitrite of amyl. This potent drug is a very efficient controller of after-pains, and, used cautiously, I see no reason to apprehend harm from it. A neat way to use it is to saturate a piece of tissue paper with five or six drops, stuff this into a two-drachm vial, and request the patient to draw the cork and inhale the odor when she feels the pain coming on. It acts with magical celerity.—*Dr. Winterburn, in Journal of Obstetrics.*

## Periscope.

## SURGERY.

## FISTULA IN ANO.

As far as diagnosing fistula in ano is concerned, that is quite an easy matter, but to tell exactly the character of the fistula we have to deal with, is quite another thing. An operation that will cure one fistula will not cure another. Therefore, no general rule will apply to these cases. There are several things to be taken into consideration in properly diagnosing or prognosticating a case of fistula.

1. Is it a simple fistula, and has it but one channel?
2. Is it a progressive or non-progressive fistula?
3. Is it due to any special diathesis, as tubercular, syphilitic, etc.?
4. Does it exist as a disease *per se*, or is it the result (secondary) of stricture?

These are essential considerations, and will decide the method of operating and after-treatment, and the prognosis.

To illustrate: If the case is one of simple fistula with but one channel, a single division of tissue, either by the knife or ligature, will effect a cure.

If it is a progressive fistula with a great discharge of pus, and a rapid breaking down of tissue, an operation *by the knife* should be advised at once. If it is non-progressive, no hurry need be had, and the patient can adapt himself to circumstances.

If the disease is due to any special diathesis, such diathesis must be ascertained in order that the proper medical as well as surgical treatment can be afforded. Indeed, upon this is decided the question whether an operation is warranted at all.

If the fistula be secondary to a stricture of the bowel, no operation is permissible until the strictured condition is righted.

I consider, therefore, that these are points of much more significance than to determine whether the fistula be an external, internal, or complete one. It has often occurred to me that the authorities put too great stress upon this division of fistula. It matters very little to the surgeon who is going to operate, which variety he is going to deal with, for

he is going to do pretty much the same operation in all. It is the complications that concern him, not this kind of division.—*Dr. Joseph M. Mathews, in International Journal of Surgery.*

## CEREBRAL SURGERY.

Hintzig (*Berliner klin. Wochenschrift*, 1892, No. 29, p. 713) has reported the case of a mason, twenty-nine years old, who, following a blow in the right frontal region, complained of pain at the site of the injury, with impairment of memory, defective intelligence, and attacks in which paresis of the left hand appeared, while the mouth was drawn to the left; speech and deglutition were likewise slightly affected. Subsequently, vision became impaired upon the right, and then upon the left. There had been no vomiting; and there was no alteration of the pulse. The head was bent strongly forward and slightly to the left; the left shoulder drooped somewhat. There was bilateral papillitis and concentric limitation of the visual fields. The muscles of the right side of the face were parietic. The tongue was protruded a little to the right. There was also loss of power in the left upper extremity. There was weakness of the lower extremities, slightly the greater upon the left side. Sensibility was not deranged. The knee-jerks were exaggerated, the left side in greater degree than the right. Ankle-clonus was present upon the left, and the skin-reflexes were exaggerated. In the right temporal region, in a situation corresponding with the anterior half of the origin of the temporal muscles, was a doughy tumefaction, painful upon pressure. A diagnosis of a tumor of the bone exerting pressure upon the brain in the temporal region was made, and operative procedure decided upon. A large extent of bone was removed in the right temporo-parietal region, leaving an opening in the skull of about  $3\frac{1}{2}$  by  $4\frac{1}{4}$  inches. The bone in places was thin; in others, thickened. A large growth was found arising from the brain and penetrating the dura. The neoplasm was carefully removed. It weighed nearly nine ounces, and proved to be a mixed sarcoma. The patient recovered absolutely from the operation, without noteworthy aggravation of his previous parietic condition.—*Medical Progress.*



### THE EXTENSION OF GONORRHEA TO THE PARS POSTERIOR URETHRÆ.

After an examination of fifty cases of first infection of gonorrhea, Dr. Heisler concludes (*Med. Era*):

1. That posterior urethritis appears much earlier than is usually taught and accepted by the best writers.

His statistics show that in twenty per cent. of the cases it appeared in the first week, in thirty-four per cent. in the second week, and in fourteen per cent. in the third week after the appearance of the discharge.

2. Constitutional affections, especially syphilis, have little influence in hastening the occurrence of posterior urethritis, although the affection occurs more frequently in syphilitic subjects.

3. Occupations which necessitate long-continued exertion play an important role in expediting affections of the deep urethra.

4. The affection is equally prevalent whether injections are used or the treatment be confined to internal medication.

5. The musculus compressor urethræ has no power to prevent the transference of the infective agent to the deep urethra.

6. The gonorrheal inflammation of the anterior urethra cannot be regarded as an affection of such typical course as is asserted by the majority of authors, *i. e.*, an inflammation starting in the fossa navicularis, reaching the bulb in three weeks; then, when the acme of intensity is attained, passing over to the posterior urethra. In the great majority of the cases, this happens during the first or second week without the direct transference of the gonorrheal pus by means of catheters or sounds.

It must therefore be looked upon, not as a complication of anterior urethritis, but as a direct continuation of it.—*Med. Review.*

### MEDICINE

#### THE POPULATION QUESTION AND SYMPHYSEOTOMY.

British obstetricians are usually averse to craniotomy or any other obstetric operation which entails the sacrifice of the child. Their scruples, however, though essentially both professional and conscientious, are based on respect for individual life rather than on any abstruse questions

connected with the maintenance of the population. Those questions are of greater import across the channel. At a recent meeting of the Académie Médécine, M. Charpentier spoke in favor of Sigault's operation, or division of the symphysis. This operation has lately been revived, and performed largely in Naples with excellent results. M. Charpentier concludes his address by the following words to French obstetricians: "Do not abandon to the foreigner the benefits of an operation which, was first successful in our country. Try once more symphyseotomy, which, while avoiding all the evil results of embryotomy and Cæsarean section, still too frequent, will allow you to save almost certainly both the lives entrusted to your care. Remember that in this respect you hold in your hands a means of diminishing infantile mortality, an aim towards which all your efforts ought to tend, for now more than ever France has need for her children." We have already noted that Professor Morisani intends to bring the subject of symphyseotomy before the International Medical Congress at Rome in 1893. The complete revival of Cæsarean section has surprised the profession, yet the resuscitation of symphyseotomy is perhaps still more remarkable.—*Brit. Med. Jour.*

#### THE NATURE AND FREQUENCY OF DISEASE OF THE SPINAL CORD IN GENERAL PARALYSIS.

The spinal cord has been examined by Dr. Köberlin in twenty-three cases of general paralysis, examination being made of pieces from the cervical, dorsal and lumbar regions in each case, and the sections were stained with Wegiert's hematoxylin and with carmine. Morbid change was seen in the lateral pyramidal tracts and posterior columns. Sometimes Goll's columns alone are degenerated, at others Burdach's columns are affected, though to a less extent in most instances. Cases were observed where Goll's columns were separated by streaks of degenerated tissue from the outlying area of Burdach's. The morbid appearances comprise atrophy and degeneration of the medullated fibres with excess of connective tissue, and the presence of numerous corpora amylacea. The degeneration was found to be remarkably symmetrical both in transverse and longi-

tudinal sections. In one case syringomyelia was found but this case the author considers atypical. The cases were classified by Dr. Köberlin into: (1) Affection of the crossed pyramidal tract. (2) Affection of the posterior columns. (3) Affection of both. In one case of the first mentioned class there was a difference in weight between the cerebral hemispheres, and as the more atrophied hemisphere was opposite to the diseased lateral tract, the author is disposed to think that the pyramidal degeneration was secondary. Amongst the cases in the second class he gives reasons for considering the cord-disease as primary in some; in others the disease was probably first developed in the brain. In none of the twenty-three cases were the anterior columns or the lateral cerebellar tracts diseased.—*Dublin Journal of Medical Science.*

#### CONGENITAL BALDNESS AND PEMPHIGUS.

Bar (*Arch. de Tocol. et d' Obstét.*, December, 1891) exhibited before the Société Obstétricale de Paris a child born with circular patches of baldness on the hairy scalp, and a bulla of the character of pemphigus on the right hand. He suggests that the patches on the scalp might represent pemphigus at its last stage, although that disease is rarely seen after birth, except on the hands and feet. There was talipes in this case, and the pregnancy was complicated by hydramnios. No positive history of syphilis could be obtained.—*Brit. Med. Jour.*

#### THE CHANGES IN THE BLOOD IN DISEASE.

Sadler (*Fortschritte der Medicin*, Bd. x., 1892) reports the result of a large number of observations made at the clinic of v. Jakach, at Prague, upon the blood in various pathologic conditions. It appears that the number of red corpuscles is diminished, though, as a rule, not considerably, in the course of acute disease. In chronic disease, especially when cachexia develops, the diminution may be decided. Under the same conditions, the hæmoglobin suffers a diminution relatively greater than that of the corpuscles. To these generalizations, tuberculosis, especially if the patient be well nourished, and valvular disease of the heart, especially

mitral disease, may constitute exceptions. In some cases of chlorosis, the number of red cells may for a long time be almost normal, while the proportion of hæmoglobin is considerably diminished. On the contrary, in cases of anæmia there is decided diminution both in the number of red corpuscles and in the proportion of hæmoglobin. The greatest diminution in the number of red corpuscles occurs in pernicious anæmia, though almost as profound a change may be observed in the case of anæmia following hemorrhage or resulting from other causes, such as atrophy of the glands of the stomach. In cases of pernicious anæmia, Sadler failed to find hæmoglobin in relatively greater proportion than the number of red corpuscles. In cases in which as a result of acute, profuse diarrhoea, the consistency of the blood was augmented, the number of corpuscles and the percentage of hæmoglobin were increased. A similar condition appeared in some cases of enteric fever. In untreated cases of malarial fever, the number of white corpuscles is increased. Physiologically, leukocytosis is present during digestion. Leukocytosis is also present in the puerperal state, at least for twelve days following labor. The white corpuscles are usually in excess in acute diseases attended with exudation, viz., pneumonia, pleurisy, peritonitis, pericarditis, meningitis, polyarthritis. It seems likely that there is a relation between the character of exudation and the presence or absence of leukocytosis. If leukocytosis appear in the course of enteric fever it must be considered as evidence of the existence of a complication. Leukocytosis occurred in pulmonary tuberculosis only after injections of tuberculin. Leukocytosis was present in a minority of cases of carcinoma. Four cases of sarcoma present leukocytosis. There was little or no excess of leukocytosis in three cases of lymphadenitis.—*Amer. Jour. Med. Sci.*

#### EPILEPTIC MANIFESTATIONS RESEMBLING WRITER'S CRAMP.

Dr. Féré (*Gaz. des Hôpitaux*) speaks of a patient in whom the epileptic aura took the form of a cramp similar to that seen in writers.

The manifestation becomes general so that the attack soon resembles one of ordinary epilepsy.

As soon as the attack is passed he is able to write again, which renders the differential diagnosis easy, since this would not be the case in true writer's cramp. The bromides when given produced marked improvement.

### OBSTETRICS.

#### HYDATIFORM MOLE.

The following is a general outline of the treatment prescribed by Dr. George A. Cragin (*Boston Med. and Surg. Jour.*): When diagnosis cannot be made these cases must be treated on general principles, and it must often happen that nothing is done until hæmorrhage, exhausting nausea and vomiting or convulsions indicate the immediate emptying of the uterus. When once the diagnosis is made the following points have important bearing on the treatment:

1. The patient is liable to repeated hæmorrhages sufficient to cause grave general disturbances, and to sudden severe hæmorrhage.

2. The closed, rigid os is almost the rule even after severe hæmorrhage.

3. The mole can be delivered without complete dilatation, and with no more loss of blood than is almost certain to follow later, when it may not be easy to interfere.

4. The uterus contracts well after being emptied, even when pains have not been present before dilatation was begun.

5. Uterine stimulants and tampons will generally have to be supplemented by the hand or curette.

6. Tampons with delay increase the danger of infection.

7. Incomplete expulsaion makes hæmorrhage and sepsis liable.

8. The possibility of a thin uterine wall should be borne in mind when the curette, the hand in utero, or Crede's method of expression are used.

In the light of the above facts the proper course to be followed is clear. The uterus should be emptied as soon as possible. Just how to begin this, however, may be a question. To rely upon tampons, colpeurynter and ergot would be poor practice. The process is slow and imperfect; hæmorrhage and exhaustion greater. Yet in cases with rigid os and long, dense cervix, undoubtedly the firm

vaginal tampon is a most effective means of starting up pains, and getting a soft, dilatable os.

#### ON THE PREVENTION OF LACERATIONS OF THE PERINÆUM PRIMIPARÆ.

The experience gained in a large midwifery practice here for some years has convinced me that the following suggestions, if thoroughly and carefully attended to, will, in the large majority of cases, allow of the passage of the fetal head with laceration of the perinæum; and this is borne out by the fact that in primiparous cases where the child was born before my arrival I have invariably observed some degree of laceration of the perineal tissue. I do not consider that the mere "supporting" of the perinæum during the birth of head is, *ipso facto*, sufficient to prevent laceration; it is but a factor in the result desired, and is beneficial by delaying any too rapid advance of the presenting part. The chief causes of rupture of the perinæum are undoubtedly—

1. Too rapid advance of the presenting part before sufficient dilatation of the parts has had time to take place.

2. Abnormal rigidity of the parts.

3. The outlet is too small or the presenting part too large.

As the presenting part reaches the perinæum the parts are expanded in all directions, and, therefore, two fingers, well anointed with antiseptic uterine lubricant (Summer's), should be used during or directly preceding the pain in order to assist dilatation by expanding the perinæum in every direction. During the intervals between the pains a sponge wrung out in warm water aseptic with carbolic acid should be applied to the perinæum, the result being some softening of the parts by relaxation of the soft parts, and in addition this application is grateful and comforting to the patient and facilitates the removal of any mucous or excreta during the passage of the presenting part. Supposing the head to present, as is more commonly the case, as labor progresses pressure should be exerted upon it in a direction to promote flexion of the chin upon the sternum, and this manœuvre not only places the head in a more favorable position for passing the perinæum but is sufficiently dilated to prevent any rupture of the same.—Charles H. Miles, L. R. C. P. Lond.—*In Hosp. Gaz.*



#### THE USE OF IPECACUANHA IN UTERINE INERTIA.

Drapes says this remedy in simple atony of the uterus is a powerful agent in producing uterine contraction during the first and second stages of labor.

In general, two or three doses of from ten to fifteen drops of the wine of ipacacuanha, given at intervals of ten minutes, produce in a short time marked activity of uterine action and a rapid birth. It is much better than ergot, as it does not produce tetanic contraction, but only induces normal and regular explosive efforts. —*Ex.*

#### GYNECOLOGY.

##### TECHNIQUE OF CÆSAREAN SECTION.

Chas. Jewett, M. D., in discussing this subject in the *New York Journal of Gynecology* says, the objection to the rubber tube, in the provisional ligation of the cervix, that it is liable to injure the tonicity of the muscles, is obviated by employing a large tube with thin walls, which spreads as it is drawn taut and distributes the pressure over a large surface. It is the practice of Sanger and others after separation of the placenta and membranes to scrub the cavity with a fold of gauze. In the absence of infected fluids after peeling off the membranes the uterine cavity should be left literally untouched. The endometrium is left aseptic after removal of the secundines, and antiseptic douching or scrubbing is not only uncalled for but injurious; a septic uterus on the other hand should not be trusted to the conservative operation at all, but should be amputated. With care to prevent the entrance of much blood and liquor amnii into the abdominal cavity, the usual peritoneal toilet may be almost wholly omitted. The obvious advantage of operating with deliberate preparation before the rupture of the membranes and with the patient in full strength furnishes a strong argument for an appointed time if possible, shortly before the expected date of labor. The main conditions of success in Cæsarean section are asepsis, and the accurate suture of the uterine wound. Reasonable rapidity, however, is important, and the length of time should not exceed three-quarters of an hour if the best results are to be expected. To these

conditions should be added the early use of saline catharsis after operation. The writer's experience, not alone in these cases, but a somewhat extensive one in analogous conditions, leads him to place a high value on early resort to peritoneal drainage by the intestines.

#### HERNIA OF ABDOMINAL CICATRIX AFTER LAPAROTOMY.

Goullioud (*Arch. de Tocol. et de Gynec.*, July and August, 1892) compares the ventral hernia of pregnancy and abdominal tumor with the troublesome hernia of the cicatrix after ovariectomy and other forms of abdominal section. In the first form, common amongst multiparæ, the linea alba is simply relaxed through excessive distension of the tissues which compose it. The aponeurotic layer of the abdominal walls remains entire, though thin, like the skin, and peritoneum, from stretching. In hernia after operation, the protrusion is due to non-union of the aponeurotic layer of the linea alba. Hence Goullioud maintains that the aponeurotic layer of the abdominal incision should always be united by a special line of sutures. Three radical operations for the cure of hernia of the cicatrix are practised. Simon inverts all three layers and, making raw surfaces on the skin, unites them by suture. Maydl resects the entire sac and applies a special line of suture to each layer. In a third method the skin is resected, the other layers inverted, and their folded edges sutured, and lastly the edges of the skin wound united by a separate line of suture. This operation, advocated by Chrobak, is more suited for ventral herniæ not due to operation. It has the advantage of avoiding the opening of the abdominal cavity. Complete resection, however is as a rule preferable in hernia after ovariectomy, etc. The serous layer of the sac usually possesses secondary pouches, bands and omental adhesions. Their removal is clearly an advantage. Guillioud warns the surgeons of the difficulties of resection. The three layers are fused by tissue more or less dense. Hence free excision of the sac renders the operation less irksome, and is more advisable to the patient; the further the surgeon cuts from the limits of the cicatrix the easier will be the separation of the layers. When separated, after long and careful dissec-

tion, they must be sutured separately. The fibrous ring forming the neck of the sac often gives great trouble. The operation of resection is most likely to succeed when the recti are not overstretched; when, in fact, they still contract firmly. A perfect union of the aponeurotic layer is, of course, essential. Without such union the secondary operation will be followed by a yet larger hernial protrusion. —*British Medical Journal*.

#### A DERMOID CYST CONTAINING A HEART.

At the October meeting of the Academy of Medicine, Dr. J. A. Johnstone related (*Cincinnati Lancet-Clinic*, October 15) a case of this nature, exhibiting the specimen. He said:

The object in reporting this case is to show something very unique, and something I have never found before in a dermoid cyst—the interior of this gives you a very well-formed attempt at the formation of a heart. My second reason for making the report is to show what nature will do towards saving the life of patients who have had accidents. This tumor existed for several years. The patient was an Irish girl aged about twenty-five years, and gave a very indefinite history. Along in July last she had an attack of pain in the abdomen, and she said it seemed as though she was going to die right away, but it all passed off. However, when I came to do the operation, the cause of the pain was very apparent. The axis had been rotated upon itself almost twice and a half. The axis being the round ligament, this had been enough to excite a very marked peritonitis. The tumor was adherent, tremendously large vessels passing into it. The tumor was slate-colored at the time of the operation.

This attempt at the formation of a heart is something of which I never knew. There is a case recorded where an eye was pretty well formed, the cornea being well shown. Gray matter of the brain has been found, and, in fact, all portions of the hypoblast and mesoblast have been found. I am led to believe that the simple variations of the cyst is the fault of the Graafian follicle, but the formation of the dermoid is due to the ovum, which is retained, and in some way or other produces this formation.

The patient recovered.

#### HYSTERECTOMY.

Mr. Lawson Tait contributed to the Obstetrical Society of London (*N. Y. Jour. of Gyn. and Obst.*) notes of two cases of hysterectomy. The first patient was fifty-two years of age; had ceased to menstruate two years ago, and during the two months before Mr. Tait saw her the tumor had grown more rapidly. It reached up to the sternum and pseudo-fluctuation was distinctly present. When the abdomen was opened the tumor was found to be a myoma, and fluctuation was so distinct that a trocar was plunged in, and six pints of fluid removed. The tumor (which weighed about five pounds) was clamped and removed. The patient made an uninterrupted recovery. The second case was that of a woman, aged forty-two, who had had three children, all the labors being normal. When thirty-seven years old she began to lose profusely, and then noticed a substance in the lower abdomen. A large, multinodular myoma, reaching above the umbilicus, was found on admission, and the appendages were removed May 13, 1888. She reported herself July 26, 1890. Menstruation had not recurred, and she felt perfectly well. The tumor was found to have nearly disappeared. Later on metrorrhagia recurred; the uterus was explored for polypi, but none were found, and the endometrium was curetted with temporary relief. The discharge came on again, and the tumor had again increased in size; so on October 12, 1891, hysterectomy was performed. The old multinodular myoma was hardly to be seen, but a large, independent growth of a soft, endematous character had grown to the size of the original tumor. The patient made an uninterrupted recovery. The case was a unique example of a soft myoma springing up after a multinodular one had been removed; and Mr. Tait considered that whilst the latter variety of myoma was a disease of menstrual life, the former was not so.—*Med. Review*.

Laparotomy for the treatment of tubercular peritonitis gives very flattering results. The ascitic form gives a mortality of 20 per cent., permanently cured at the end of a year 35 per cent. of cases. The dry, fibrous type of the disease gives a mortality of 10 per cent., and of those

who survived the operation 50 per cent. were living and well at the end of the year. The purulent ulcerous type of peritonitis gives 40 per cent. of mortality and about 25 per cent. remain permanently well. In tubercular peritonitis of genital origin, about 25 per cent. remain permanently well.—*Ex.*

#### VAGINAL HYSTERECTOMY IN PELVIC SUPPURATION.

At a recent meeting of the Paris Surgical Society. Dr. Terrillon spoke favorably of this extreme measure. He has operated on four cases of old-standing pelvic suppuration with hectic exacerbations and rectal and vaginal fistulae.

The first patient had been ailing for two years subsequent to a miscarriage; parametric infiltration extended up as high as the navel, and the uterus was firmly fixed in the inflammatory deposit. Abdominal section proved useless; the omentum could not be detached, and the intestines were so firmly adherent that no attempt was made to liberate them. The uterus was at once extirpated from the vaginal side. On the twenty-eighth day serous symptoms developed—owing to retention of pus behind the vaginal fistula cicatrix. The fever ceased as soon as an exit was made for the pus; but a vagina fistula remained.

In the second case—similar to the first—abdominal section was found impracticable, and vaginal hysterectomy was performed eight days later, with the result of effecting a complete cure.

In the third case the patient had been ill for nine years, and was suffering from a lichenous eruption which had been attributed to septicæmia; albuminuria, vomiting and fever were present. Vaginal hysterectomy proved very troublesome, and considerable shock followed. Nevertheless, the patient recovered, and the annoying eruption disappeared.

The fourth patient had been ill for twelve years, and had suffered from severe continuous pain and fever since two months. Vaginal hysterectomy was performed on the left side; the vagina cicatrized nicely, but a rectal fistula remained.

The last mentioned case is sufficient to show—according to the author—that the operation does not always bring about a radical cure; the first two cases, on the other hand, demonstrated that vaginal

hysterectomy may succeed after abdominal section has proved of no avail. Although the operation appears especially desirable in cases where there is a well-incysted abscess, Dr. Terrillon considers it required in cases of old extensive and ill-defined suppurative processes with fistula, adhesions, and parametric infiltration of the parietes.—*Merck's Bulletin.*

#### HYGIENE.

##### THE PATHOLOGICAL EFFECTS OF HEAT.

Some interesting observations have been recorded by Drs. Coplin, Bevan, and Sommer on the effects of heat as manifested in workmen in a sugar refinery in Philadelphia. During the very hot weather the number of men on duty was 800 during the day, and 500 during the night, and in the course of eight days 213 of these came under treatment. The most common and troublesome symptom complained of was cramp in the epigastrium, with not infrequently similar pain in the calves, sometimes in the back and hypogastrium, less commonly in the thighs and upper extremities. Other symptoms were difficulty of respiration, pain in the splenic or hepatic regions, headache in nearly all cases, nausea, rarely vomiting, agitation, pale skin (if moist, cold, and clammy). In a few cases diarrhoea was present, in the majority constipation preceded the attack. Later delirium, sometimes active, came on, with convulsive movements, ending, in fatal cases, in coma. The pulse was irregular, the urine scanty and high-colored. Pain in the cervical region, and generally in the back, was complained of; the patient may be conscious of the high temperature, but as a rule he felt cold when brought out of the intense heat. There was great thirst. The pathology of the cases was obscure, but the symptoms pointed to a large accumulation of blood in the portal system. The area of hepatic dullness was largely increased, as a rule, in proportion to the intensity of the attack, and the same increase could be noticed in regard to the spleen. Curiously enough, the rectal temperature was two to five degrees higher than the oral. With regard to the temperatures of the men who complained, in two the temperature was 108° F.; one of these died, the temperature reaching 110° F. In twenty-eight the



temperature was 105° F., in fifty between 102° F. and 105° F. In the remaining 133, the temperature in sixty-two was above 101° F.; in forty-nine between 100° F. and 101° F.; in eight between 99° F. and 100° F.; in eleven between 97° F. and 99° F.; in one, 96° F.; and in two between 95° F. and 96° F. There were more cases of illness in the rooms where the atmosphere was humid than in those where it was drier, and there was no evidence that men who drank beer freely suffered as much as those who drank little or none at all, while those who drank largely of water were extremely prone to suffer.—*Med. Press.*

#### DIETETIC TREATMENT OF TYPHOID FEVER.

In a recent article on this subject by Beatty Wallace, he claims that milk is the safest and best diet.

It may be diluted with soda water or lime water and may be peptonized.

\* Should diarrhoea exist, the milk may be boiled.

If the patient can take milk alone it is the best food during the entire illness.

Beef tea may also be given, and is a useful addition to milk.

Farinaceous foods he considers objectionable because of the flatulence following their use, and the liability of a fresh outburst of fever.

Beaten up eggs should be avoided unless milk cannot be taken.

In any case two or three pints of liquid food will be found sufficient for an adult each day.—*Epitome of Medicine.*

#### NEWS AND MISCELLANY.

##### IDIOPATHIC.

This a word used very frequently by the profession, but it is doubtful whether it is a proper term. If by the term we mean a disease without an underlying cause, it certainly has no place in medical nomenclature. When we cannot say what ails a patient it is better to say that we do not know than to use the word idiopathic. "Idiopathic" plaritis and "idiopathic" pericarditis are slaying hundreds of people to-day. "Idiopathic" peritonitis slew thousands of women before it was demonstrated that peritonitis never existed without underlying cause.—*Ex.*

##### USED WITH EFFECT.

A practitioner in Chicago told me that in a labor case, after giving to the husband, who was acting as nurse, the usual order, "Let me know if everything is not right," he left. In the course of a few days, the nurse called on the doctor to ask if the foul odor could not be stopped. He said, "Did you use the syringe I gave you?" "Oh! yes, doctor, and although it does not affect the odor, it moves the bowels finely." Another case, which was under the care of a brother practitioner in the town in which I live: The doctor took the Davidson syringe, showed the intelligent (?) nurse how to use it in a basin of water, and left happy. Next day, not liking the appearance of the patient, he inquired, "Did you use the syringe?" "Yes, doctor, but the mixture you ordered was no sooner down, than it all came up again, and everything that had been eaten for a week." It is a fact that the nurse forced a pint of soap-suds down the patient's throat, by means of the syringe.—Dr. Caldwell, *Southern Med. Record.*

##### A NATIONAL BACTERIOLOGICAL INSTITUTE.

This is advocated by the *International Journal of Surgery* which says, *inter alia*, that a central laboratory should be established by the Government equipped with all the modern appliances for the experimental study of contagia, with experimental stations, and with a staff large enough to cover the whole ground and paid well enough to secure the most efficient services. Finally, and above all, such an institution must be entirely free from the taint of politics. The Imperial "Gesundheitsamt," at Berlin, which is conducted by Professor Koch, may well serve as a model of what a modern civilized government should do in this direction. There are, to be sure, a number of laboratories either private or connected with the medical schools, but the workers there are almost invariably men who depend upon active practice or teaching for a livelihood, and who pursue bacteriological research as amateurs. The entire time and all the energies of the best men are requisite for this work. Only the Government can guarantee these conditions.

Only the Government has the force at

hand to investigate contagious diseases; and on the Government, representing the entire community, the duty devolves. Systematic and careful work in the investigation of human and animal plagues; work done on the largest scale and with the facilities that only the government can supply; this is far more important to the sixty millions of this community than petty trade and boundary disputes.—*Salus supremum jus!*—*Med. Review.*

At the recent meeting of the American Orthopedic Association held in the City of New York, September 20, 21 and 22, 1892, the following officers were elected to serve for the ensuing year: President, Dr. A. J. Steele, St. Louis; Vice-Presidents, Dr. Samuel Ketch, New York; Dr. Arthur J. Gillette, St. Paul; Treasurer, Dr. A. B. Judson, New York; Secretary, Dr. John Ridlon, 34 Washington St., Chicago. The next annual meeting will be held in St. Louis, the third week in September, 1893.

#### ELECTRICITY AND FILLED TEETH.

George E. Zinn (*Dental Review*) says: Some patients are of such a bodily temperament, as to act like Leyden jars or storage batteries. The electricity may be generated by the friction of the hands on a dry substance, such as cloth. It is not evenly distributed through the body, and whenever a metal instrument comes in contact with the tooth, there results an electric current for the equalizing of the electricity. This accounts for the pain sometimes experienced from touching one's own filled tooth.

Some dentists are likewise living storage batteries. They have their offices carpeted and the friction of their feet generates electricity, they approach the patient to examine his teeth, touch a filled one with an instrument and the patient experiences a sharp pain. This is caused by the passing of electricity from his body through the instrument to the tooth and the body of the patient by means of the connection made with the tooth. It is a well known fact that bodies have different capacities for electricity, that when two bodies unequally charged in proportion to their capacities come in contact, a current passes from the one to the other, equal-

izing the electricity of the two bodies, and it is so with regard to the patient and dentist. This explanation seems to me clear. I have heard it attributed to the "Electrical Condition" but not explained, consequently I have told my patients it was due to certain "Electrical Conditions," but never had a rational understanding of it. They, of course, would go home half believing it was so, or fully believing that it was the fault of the filling or of my work.

#### OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY FROM OCTOBER 16, 1892, TO OCTOBER 22, 1892.

First Lieutenant George D. DeShon, Assistant Surgeon, U. S. Army, is relieved from duty at Columbus Barracks, Ohio, and will report in person to the commanding officer, Fort D. A. Russell, Wyoming.

So much of S. O. 230, as relates to change of station of Captain Eugene L. Swift, Assistant Surgeon, is suspended until further orders, and he is granted leave of absence for one month, on account of sickness, with permission to apply for an extension of one month.

Captain Edward R. Morris, Assistant Surgeon, U. S. Army, is relieved from duty at Fort Custer, Montana, and will report in person for duty to the commanding officer, Fort Warren, Mass., relieving Captain Peter R. Egan, Assistant Surgeon, U. S. Army.

Captain Egan on being relieved by Captain Morris, will report in person to the commanding officer, Fort Custer, Montana, for duty at that post.

First Lieutenant Allen M. Smith, Assistant Surgeon, U. S. Army, is relieved from further duty at Fort Assiniboine, Montana, and assigned to duty at Fort Custer, Montana, where he had already been ordered to temporary duty.

Major John C. J. Happersett, Surgeon, U. S. Army, is relieved from duty at Fort Custer, Montana, and will report in person to the commanding officer, Fort Keogh, Montana, for duty at that post, relieving Major Philip F. Harvey, Surgeon.

Major Harvey on being relieved from duty by Major Happersett, will report to West Point, N. Y., and report in person to the Superintendent of the U. S. Military Academy, for duty at that post relieving Major Henry McElderry, Surgeon.

Major McElderry, on being relieved by Major Harvey, will report to Omaha, Nebraska, and report in person to the commanding general Dept. Platte, for duty as attending surgeon.

First Lieutenant William E. Purviance, Assistant Surgeon, U. S. Army, is relieved from duty at Jefferson Barracks, Missouri, and will report in person to the commanding officer, Fort Sherman, Idaho, for duty at that post, relieving Captain William W. Gray, Asst. Surgeon.

Captain Gray on being relieved by Lieutenant Purviance will report in person to the command-

ing officer, Fort Schuyler, New York, for duty at that post.

The leave of absence granted First Lieutenant Samuel R. Dunlop, Assistant Surgeon, is extended one month.

Lieutenant Colonel Charles R. Greenleaf, Deputy Surgeon General, is appointed member of a board of officers, to meet at Helena, Montana, on the first day of November, 1892, or as soon thereafter as practicable, for the purpose of selecting a site for a military post at that place, as provided for under an Act of Congress approved, May 12, 1892, entitled "An Act to establish a military post at or near the city of Helena, in Lewis and Clarke County in the state of Montana."

First Lieutenant Allen M. Smith, Assistant Surgeon, U. S. Army, is relieved from further duty at Fort Yellowstone, Wyoming, and will proceed to Fort Custer, Montana, and report to the commanding officer of that post for temporary duty.

Leave of absence for one month, to take effect upon his relief from duty at Fort Columbus, N. Y., is granted Major Johnson V. D. Middleton, Surgeon, U. S. Army.

**OFFICIAL LIST OF THE CHANGES OF  
STATIONS AND DUTIES OF MEDICAL  
OFFICERS OF THE U. S. MARINE  
HOSPITAL SERVICE FOR THE  
THREE WEEKS ENDED  
OCTOBER 15, 1892.**

Purviance, George, Surgeon. Granted leave of absence for seven days, Oct. 12, 1892.

Banks, C. E., Passed Asst. Surgeon. To rejoin station at Portland, Maine, Oct. 14, 1892.

Devan, S. C., Passed Asst. Surgeon. Ordered to Washington D. C., for special duty, Sept. 29, 1892.

Kallock, P. C., Passed Asst. Surgeon. To rejoin station at Boston, Mass., Oct. 14, 1892.

Wasdin, Eugene, Passed Asst. Surgeon. To rejoin station at Charleston, S. C., Oct. 3, 1892.

McIntosh, W. P., Passed Asst. Surgeon. To proceed to Buffalo, N. Y., for temporary duty, Sept. 25, 1892. To proceed to Ellis Island for temporary duty, Sept. 30, 1892. To report in person to the Supervising Surgeon General, Oct. 8, 1892. To rejoin station at New Orleans, La. Oct. 10, 1892.

Pettus, W. J., Passed Asst. Surgeon. To proceed to New York, N. Y., for temporary duty, Sept. 25, 1892.

Magruder, T. M., Passed Asst. Surgeon. To proceed to Tacoma, Wash., for special duty, Oct. 7, 1892.

Cobb, J. O., Passed Asst. Surgeon. To rejoin station at Detroit, Mich., Oct. 7, 1892.

Stoner, J. B., Passed Asst. Surgeon. To rejoin station at Pittsburgh, Pa., Oct. 3, 1892. Granted leave of absence for seven days, Oct. 4, 1892.

Rosenan, M. J., Asst. Surgeon. Relieved from duty at Cape Charles Quarantine, Oct. 11, 1892. Granted leave of absence for thirty days, Oct. 13, 1892.

Cofer, S. E., Asst. Surgeon. Granted leave of absence for three months on account of sickness, Oct. 15, 1892.

Gardner, C. H., Asst. Surgeon. To report to the Medical Officer in Command, San Francisco, Cal., for duty, Oct. 12, 1892.